Exploring therapists' experiences of using therapeutic interventions from Muslim perspectives for Muslim clients: usefulness, contribution and challenges in the UK.

by

Abida Choudhry

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In the name of Allah, the Most Gracious, the Most Merciful

ABSTRACT

Modern psychological approaches currently being used with Muslim clients in therapy have consistently been criticised for being decontextualised, Eurocentric, individualistic, reductionist and for not taking Muslim clients' cultural and religious values into account (Amri, & Bemak, 2013; Carter & Rashidi, 2004). Hence a need for making use of models, techniques and therapeutic interventions based on Muslim perspectives for Muslim clients has repeatedly been expressed (Haque, 2004a; Helms, 2015; Inayat, 2007; Keshavarzi & Haque, 2013; Utz, 2012; Weatherhead & Daiches, 2010).

Despite recommendations for using therapeutic interventions from Muslim perspectives with Muslim clients in therapy (Abu Raiya & Pargament, 2010; Haque & Kamil, 2012; Qasqas & Jerry, 2014), empirical research on these interventions has lagged behind (Abu-Raiya & Pargament, 2011). The aim of the current study is to provide more insight into how interventions from Muslim perspectives can be administered by Muslim therapists with their Muslim clients in therapy in United Kingdom.

This study explored the experiences of six Muslim therapists who were all using interventions from Muslim perspectives with Muslim clients in their therapeutic practice. Semi-structured interviews were conducted, transcribed, and analysed using Interpretative Phenomenological Analysis (IPA), and from this three main themes emerged (i) Psychotherapeutic approaches, (ii) Journey of becoming a Muslim therapist (iii) Obstacles faced by Muslim clients and therapists. The implications for further research and therapeutic practice have also been considered.

DEDICATION

To the one who has sacrificed much for me; whose support, patience and compassion throughout this journey inspired me the most; my wonderful six year-old son,

Aahil Ahmad Raja

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Praise belongs to Allah, the One who has blessed me in this entire affair. Nothing can be accomplished without His help.

My deepest gratitude for family and friends who have provided continuous support, especially to my mother for her prayers and for instilling the importance of knowledge in me, even though not formally educated herself she is one of the most intelligent and inspiring women in my life.

I am grateful to all the participants for their time and effort in helping me to create a piece of research that is very close to my heart, and means so much to me personally and professionally.

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RESEARCH DOSSIER

1. INTRODUCTION

1.1 OVERVIEW

Evidence suggests that psychological distress experienced by Muslims living in the West has intensified. Factors influencing this include Islamophobia, microaggressions, prejudice, hate crimes, religious identity threats, acculturation problems and trauma experienced by Muslim refugees (Demirkaya, 2014; Hankir, Carrick & Zaman, 2015). Because of this, there has been an increase in Muslim clients needing therapy and therapists often find themselves at a loss to intervene effectively (Rassool, 2015). Muslim clients often experience this situation as the inability of therapists to understand their needs and provide treatment within a religious and spiritual context, since they often want their concerns to be addressed from a religious viewpoint (Abdulah, 2002; Amri & Bemak, 2013; Haque, Khan, Keshavarzi, & Rothman, 2016; Killawi, Daneshpour, Elmi, Dadras & Hamid, 2014; Podikunju-Hussain, 2006).

Muslim clients are primarily offered therapy with a Eurocentric, secular or Judaeo-Christian traditional worldview, which is rooted in the religious and cultural heritage of Western society, and does not always reflect their needs (Rassool, 2015). Muslim clients' understanding of distress and healing are usually rooted in the religious and spiritual paradigm of Islam (Carter & Rashidi, 2004; Eltaiba, & Harries, 2015; Hamdan, 2007). Therefore, a need to employ therapeutic interventions from Muslim perspectives with Muslim clients has repeatedly been expressed (Abu Raiya & Pargament, 2010; Haque & Kamil, 2012; Qasqas & Jerry, 2014).

Interventions from Muslim perspectives incorporate the Islamic notion of spirituality and religiosity into the therapeutic process (Rassool, 2015). These interventions are largely guided by the principles of Islamic beliefs and practices located in two major sources of Islamic doctrine (Haque, 2004b): The holy book of Qur'an and Hadith and Sunnah (the teachings, sayings and deeds of the Prophet Muhammed, Peace Be Upon Him (PBUH): a necessary phrase attached to the names of the prophets in Islam as a mark of respect). According to Rassool (2015), interventions from the Muslim perspective may include "therapeutic skills, giving advice (when appropriate), educating the client in the creed (*Adeedah)* and Islamic jurisprudence (*Fiqh*) and utilising traditional healing practices to facilitate clients' psychological and spiritual growth and development" (p 22).

There is a concern that Muslim therapeutic interventions have not been uniformly implemented or monitored, and require further development and guidelines for practitioners for these to be integrated into a theoretical and practical framework (Abu-Raiya & Pargament, 2011). This needs more research, a purpose to which this research is directed.

The researcher within this introduction will discuss her background within the context of this research, define the terms, and give a brief description of the Muslim profile in the UK and their current socio-political context, fundamental issues relating to Muslim culture and religion and its relevance to therapy. Existing literature in the field will be introduced and explored more fully in the literature review section in order to position this study in relation to existing research. Finally, the aims of this research will be put forward together with the questions that stimulated it.

Researcher's Context

The researcher is a Muslim and has worked with an addiction service and in school settings during her training for a professional doctorate in counselling psychology. Her preferred therapeutic orientation is the existential phenomenological approach; she also used psychodynamic approach, attachment and systemic therapy in her therapeutic practice. She has had limited exposure to working with Muslim clients and has never undergone therapy with a Muslim therapist nor used or experienced Muslim therapeutic interventions in therapy. She had therapy with a non-Muslim English therapist who had valued her religious and spiritual beliefs fully, however, left her thinking about the missing link for coping strategies from a Muslim perspective, which researcher had used simultaneously outside therapy. This led her to enquire into how these strategies could be integrated into mainstream therapy for Muslim clients.

During her research the researcher endeavoured to 'bracket' or to set aside her expectations, biases, preoccupations and her religious and cultural framework, and to understand what has been said to her within research participants' frame. Total bracketing, as Heidegger (1962) argued, is almost impossible. This research is therefore coloured by researcher's understanding of Muslim therapeutic interventions. It may prove helpful if some possible biases and frameworks affecting the researcher are clarified (Ortlipp, 2008).

Researcher was born and brought up in a Muslim family where religion and spirituality was highly valued. At a very young age, she also learned how to find comfort in religious and spiritual beliefs and practices, such as finding comfort by reading the

Qur'an in times of adversity. Later in life, she also worked with a Sufi, where she developed her knowledge in the spiritual path of Sufism. During her Masters degree in Psychology in Pakistan, she was taught about the Muslim ancient healing tradition.

Since she has moved to the UK, she has gained several qualifications in psychology in the past 14 years. This enabled the researcher to embrace her cultural, religious and spiritual heritage as well as appreciate knowledge of modern psychology and global values. This will be visible in this research, as an attempt has been made to highlight the importance of incorporation of both modern psychology and the Muslim healing tradition in therapy for Muslim clients.

The research supervisor was a non-Muslim who has substantial knowledge and experience of working with Muslim clients in his clinical psychology practice, and has a particular interest in research on Muslim mental health.

1.2 DEFINING TERMS WITHIN THIS RESEARCH

The term 'therapist' has been used rather than 'counselling psychologist' even though this research is primarily designed from a counselling psychology perspective, so that other allied professionals such as counsellors, psychotherapists and clinical psychologists working in a similar professional capacity as counselling psychologists can be included in the study. Participants with diverse perspectives, philosophies and professional backgrounds have been chosen for the study. The purposive homogeneity sampling therefore does not refer to research participants as being identical (Smith, Flowers and Larkin, 2009), instead it is about making the sample as uniform as possible

according to their therapeutic practice and examining the points of convergence and divergence during the analysis.

This inclusive stance has been taken to ensure that the study will generate knowledge that might be applied to a variety of disciplines and benefit Muslim clients consulting different types of therapist. The research participants within the current study were a counselling psychologist (n = 1), systemic therapist (n = 1), counselors (n = 3), and a clinical psychologist (n = 1). However, all the participants had a background in counselling and utilised counselling and psychotherapeutic approaches and skills in their clinical practice; therefore their work will be referred to as 'counselling' and 'therapy' interchangeably.

In the previous literature, the terms 'therapeutic interventions from an Islamic or Muslim perspective', 'Muslim/Islamic psychological interventions' have been used interchangeably (Hamdan, 2008; Haque, 2004b; Rassool, 2000). These terms may have had a different focus at the time, but have the same goal, which was to address the variety of underlying psychological needs of Muslim clients from a faith-based perspective in therapy. The current research has used the term 'therapeutic interventions from Muslim perspectives' or 'Muslim therapeutic interventions' interchangeably, used in a broad encompassing manner: healing practices based on Islamic beliefs and practices derived from the Qur'an and Hadith and from work of early Muslim philosophers (also called as Sufis) such as Ghazali (1986) although these may all be interlinked in the broader arena of the Islamic worldview on mental health and healing.

The term '*Muslim'* perspectives is being used as opposed to the '*Islamic'* perspective when discussing traditional healing practices of Muslims, this is to take the Sufi perspective of healing into account. Sufi philosophers' thoughts were mainly directed by Islamic principles, however some Sufi beliefs or practices such as Sufi Whirling (a form of physically active meditation; beyond the scope of this study) have been considered as contrary to original 'Islamic' teachings by some scholars (Rassool, 2015; Utz, 2012). The current study however takes an inclusive stance in order to capture the diverse Islamic healing beliefs and practices as well as Muslim philosophical models of traditional healing (as discussed in section 2.3).

The notion of 'healing' within an Islamic context is perceived as a holistic conceptualisation of health wherein spiritual, physical, emotional, and mental wellness is regarded as inseparable (Rassool, 2015). A brief introduction to the Muslim client profile, its religious, cultural and social context in the UK and relevance to therapy will now be given.

1.3 MUSLIMS IN THE UK

Muslims constitute the fastest-growing religious minority in the United Kingdom (UK) approximately 2.7 million, according to the Office of National Statistics (2013) in 2011. Muslims have a long history of presence in the UK from the middle ages onwards (Muslim Council of Britain, 2002).

1.4 MUSLIMS' RELIGION AND CULTURE

Muslims believe in Islam and in the 'oneness' of God (Allah). Muslims also believe in the Prophet Muhammed (PBUH) and the divine book Qur'an. Although Muslims are a

community of believers with a fellowship of shared values and concerns, in the UK they come from diverse ethnic backgrounds (Amnesty International, 2012). Each ethnic group has underlying cultural norms that intertwine with the religion. It is therefore important to delineate the Islamic religious worldview and the cultural worldview dominant to the individual group (Podikunju-Hussain, 2006). While embracing the diversity of Islam, the therapist needs to be aware of the numerous sects (e.g. Sunni, Shia or Wahabi) within Islam and different interpretations of the same Islamic belief or practice according to these sects (Inayat, 2007).

The impact of acculturation should also be taken into consideration, since half of the Muslim population living in the UK is second or third generation immigrants (Ali, 2008). These Muslims may be perceived as being "acculturated" or "integrated" in Western society, as they may follow Western-oriented lifestyles and behaviour (emotional, cognitive) while maintaining their Muslim identity (Rassool, 2015). The tension that is commonly experienced is a continual balancing of cultural values and religious beliefs when assimilating and acculturating into the larger Western culture (Podikunju-Hussain, 2006).

Therapists also need to be aware that whilst for most Muslims religion is important, not all Muslims are religious or want their mental health issues to be addressed from a religious viewpoint (Rassool, 2015). This needs to be recognized at the initial assessment in order to offer an appropriate formulation and treatment plan (Arthur & Collins, 2010). Besides paying attention to Muslim clients' religious and cultural make up in the UK, it is crucial to take their current socio-political context into consideration

as that may have an impact on their mental health as well as the therapeutic process. The next section illuminates this further.

1.5 THE SOCIO-POLITICAL CONTEXT OF MUSLIMS AND IMPLICATIONS FOR THERAPY

The current spate of incidents due to radicalization and Islamophobia has resulted in Muslims finding themselves under intense scrutiny (Hankir et al, 2015). The term Islamophobia defined as anti-Muslim sentiment, (prejudice against, hatred towards, or fear of the religion of Islam or Muslims), has its historical antecedents in the demise of communism and the rise of Islam as the newly constructed threat to Western world (Commission on British Muslims & Islamophobia, 2004; Phillips, 2006; Runnymede Trust, 1997). The term is now widely used and some commentators have dated the increase in Islamophobia to the terrorist attacks on 9/11 and 7/7 (Abu-Raiya, Pargament, & Mahoney, 2011; Inayat, 2007). It has been sustained by (often intertwined) anxieties about terrorism, and recent terrorist activities in the Europe such as the Paris attacks and more recent attacks in England; and also the growing numbers of asylum seekers in Britain (Farooqi, 2006). Muslims feel continuous pressure, on one hand they may feel compelled to clarify their religious beliefs, and on the other feel guilt by association with the perpetrators of the terrorist acts, and are often surrounded by unsettling anger in their communities (Inayat, 2007).

According to Tell MAMA (Measuring Anti-Muslims Attacks; 2015) there has been a 326 per cent increase in violence and hate crimes against Muslims in the UK in 2015, and following 'Brexit' (the term referring to UK's decision to withdraw from European Union) racially or religiously aggravated offences and hate crime recorded by police in

July 2016 were 41 per cent higher than in July 2015 (Tell MAMA, 2016). The numerous challenges that Muslims face in the UK, including violence, discrimination, marginalization, identity threats and being negatively stereotyped (Laird, Amer, Barnett, & Barnes, 2007; Phillips, 2006), affects them on a day to day basis, but could also be translated into a therapeutic context affecting Muslim clients having a fear of being misunderstood or stereotyped by a therapist perceived as lacking in understanding of their beliefs (Ali, Liu & Hum, 2004; Amri & Bemak, 2013; Killawi et al, 2014).

In some cases, they perhaps conceal their religious beliefs and feel distanced from the therapist; this could even be linked to potential therapeutic relationship breakdown (Abu-Raiya, & Pargament, 2011). Inayat (2007) further reported that Muslims in such situations tend to have difficulty in connecting with their therapists and trusting their formulation of treatment goals. Ali et al. (2004) also highlighted that in the current social and political context, Muslims in the West as a religious minority may experience greater challenges in establishing a trusting therapeutic relationship and may drop out prematurely (Raja, 2005).

Thus, effective therapy for Muslim clients means taking into consideration their religious, spiritual, social and cultural context, focusing on their feelings of connectedness within the therapeutic process and offering interventions that are congruent with their value system. Haque (2004b) further suggested that in order to work effectively with Muslim clients, psychologists need to work at a theoretical and practical level to integrate Muslim traditional healing practices in therapy. This would entail clarifying Muslims' mental health beliefs and coping strategies (Haque, 2004b). This is also the aim of the current study. The literature review will provide some insight

into what these interventions may entail and how they can be incorporated into therapeutic practice with Muslim clients.

2. LITERATURE REVIEW

The purpose of this review is to present the empirical evidence relevant to how therapeutic interventions from Muslim perspectives can be used with Muslim clients in therapy. It aims to position this study as regards other literature in the field, and also to highlight any areas where further research could be useful. Since Muslim therapeutic interventions are religious and spiritual in nature (Rassool, 2015), it is important to shed some light on the relationship between religion, spirituality and mental health. A critical stance has been taken throughout to bridge the gap between mainstream psychological approaches and Muslim therapeutic interventions.

2.1 REVIEW STRATEGY

Between 2012 and 2017 relevant research articles were identified using a search of electronic databases hosted by EBSCO (e.g. PsychINFO and Science Direct). Bibliographies of texts were scanned for seminal publications and Google Scholar was employed to identify further publications. No specific dates limiting the search were included. The following keywords: “Islamic counselling, “counselling Muslims”, “Muslim mental health”, “spirituality in therapy”, “empirical evidence for religion and spirituality in therapy” “prayers in therapy” “religion and counselling psychology”, “Sufism”, “Ruqya”, “spirituality, religion and modern psychology”, “Humanistic psychology and religion”, “Jung on religion” “spiritual dimension in existential approach”, “CBT for religious clients”, “ethical issues for using spirituality in therapy”, “Supervision for religious issues in therapy” and related terms were used. Books pertaining to these topics were reviewed at the University of Wolverhampton and the University of Surrey libraries. Zetoc alerts were used to keep up to date with new publications.

The literature review will begin by giving an overview of mainstream therapeutic approaches and their relevance to Muslim clients in therapy.

2.2 RELIGION, SPRITUALITY AND PSYCHOLOGY

2.2.1 HISTORY

The emergence of modern psychology as a scientific discipline enthusiastically embraced the principles of objectivity, empiricism, and transparency, and freed it from the bondage of culture and religion, with a vision of universally applicable psychology (Moodley, Rai & Alladin, 2010). Psychological theories and approaches such as cognitive psychology and psychoanalysis were simply assumed to be universally applicable and were adopted by psychologists worldwide, including Muslim psychologists (Abdullah, 2002). However, when modern psychology based on the individualistic, reductionist, materialistic and secular orientations of the West were applied to Muslims in eastern countries, many Muslim psychologists such as Badri (1979), Azuma (1984) and Rizvi (1985) began to question its applicability within the Muslim domain.

Azuma (1984) criticised Western psychological knowledge for being Eurocentric and not easily generalisable to the behaviour of people in other cultures. Badri (1979) stated that most Western psychological perspectives such as psychoanalytic, behaviouristic and cognitive psychology had initially denied the notion of soul. He further argued that this perspective was based on a secular worldview and would not be of much help to clients who believe in God, and the spiritual dimension of their creation. This generated much debate about religion and psychology as a science being two separate entities. It

was argued that within modern psychology human behavior is assumed to be observable and quantifiable, and therefore measurable. It ignores the 'transcendental' aspect of humans which religion embraces (Haque, 1998).

Mundra (2013) further argued that unlike natural sciences, psychology studies human behavior and cognitive processes, which include beliefs, attitudes, and values as well as religious and spiritual experiences. Therefore eliminating these aspects would give only a partial picture of the individual. Furthermore, Gergen (2001) asserted that within modern psychology there is a tendency towards reductionism, the dismantling of the 'whole', when a holistic view might provide a more accurate view of a phenomenon.

Due to the above criticism, it was argued that modern psychology has limited relevance for Muslim clients and they should be offered therapy that is more consistent with their own religious, spiritual and cultural worldview (Shah, 2005).

Previous research into Muslim mental health has made a huge contribution by highlighting the particular needs of Muslim clients. However it has created a divide between modern psychology and Islamic healing tradition by assuming that all the mainstream approaches are secular and are insufficient to address spirituality in therapy. In reality many psychotherapeutic approaches such as existential approach, Jungian psychotherapy, humanistic psychology and transpersonal therapy along with many integrative models including pastoral counselling, currently incorporate religion and spirituality effectively in therapeutic practice (Lines, 2006).

There are now recommendations to provide sufficient training on religion and spirituality in many psychiatric and psychology training institutes around the world (Koenig, 2008; Qasqas & Jerry, 2014). Counsellor and psychologists are held accountable for unethical practice for not providing a culture-sensitive care through their respective regulating bodies. For instance, Standard of proficiency for practitioner psychologists by the Health and Care Professionals Council (2015) requires the non-discriminatory practice under the ethical standard of understanding the impact of ethnicity, culture and religion on psychological wellbeing of the client. This is also an essential component of guidelines laid by the British Psychological Society (2011) for psychological assessment and formulation that psychologists take these dimensions into consideration in order to offer an appropriate treatment plan.

Research into Muslim mental health however continues to report that Muslim clients' spiritual and religious needs are not being met within the mainstream therapy. The next section therefore will examine the relationship between religion, spirituality and modern psychology.

2.2.2 The Relationship between Psychology and Spirituality

Historically, religion and mental health care has been closely aligned, since many of the first mental hospitals were located in monasteries and run by priests (Haque, 1998; Koenig, 2009). Religion was believed to have had a positive impact on these clients (Koenig, 2009). It was only in the 19th century when some influential psychologists such as Freud (1907) and Skinner (1953) showed direct antagonism towards religion, embodying a traditional view about psychology as a science that should be kept separate from religion (Haque, 1998; Koenig, 2009). Freud (1907) described religion as an

illusion, the result of wish fulfilment rather than reason. Skinner (1953) further claimed that religious behaviour is the same as other behaviours, occuring because it is followed by reinforcement. Ellis (1986) also declared that religion incorporates the concepts of sin and guilt. This heavily influenced the thinking of Western psychologists who adopted a secular worldview about human nature, and created a deep divide that separated religion from mental health care for the next century (Koenig, 2009).

Although it remains complex and controversial, the relationship between religion and mental health has now begun to change (Gonsiorek, Richards, Pargament, & McMinn, 2009; Koenig, 2009). The psychodynamic approach is now able to recognise that for most clients with religious orientation, therapy cannot be effective unless there is some representation of religion and belief in God made available in therapy, as the concept of God plays a psychic role in clients' minds throughout their developmental stages (Smith, & Handelman, 1990). Jung (2001) also considered religion as an essential function of human psychology in the absence of which the individual falls victim to various forms of neuroses and psychoses. Existential and humanistic psychologists such as Kierkegaard (1989) and Maslow (1964) also considered the spiritual dimension as an essential part of growth and self-actualization. Cognitive Behaviour Therapy (CBT) also seems to have come full circle from denial to an appreciation of religion's effect on human cognition, behaviour and emotions (Naeem, Gobbi, Ayub, & Kingdon, 2009). Researchers have demonstrated the positive effects of religious imagery (a form of cognitive therapy) on depression, with religious clients (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992).

Part of this change in postmodern psychology has been driven by an increase in research over the past two decades that suggests religious influences are not pathological, but can actually represent resources for health and well-being (Koenig, 2009).

2.2.3 Religious and Spiritual Coping in the West

A host of research in many countries around the world highlighted that religious coping is widespread. A survey of 406 patients with persistent mental health difficulties at a Los Angeles County mental health facility found that more than 80% of respondents used religion to cope and spent as much as half of their total coping time in religious practices such as prayer (Tepper, Rogers, Coleman, & Malony, 2001).

In another survey study, conducted by the Center for Psychiatric Rehabilitation at Boston University, a sample of 157 individuals with schizophrenia, bipolar disorder, or major depression were asked about the types of alternative health care practices they used (Russinova, Wewiorski, & Cash, 2002). The most common beneficial alternative health practice reported by individuals with depression and schizophrenia was religious/spiritual activity (Russinova et al, 2002).

Similarly, a study conducted at Broken Hill Base Hospital in New South Wales with 79 psychiatric patients, found that 79% rated spirituality as vital to their recovery, 82% thought that their therapists should be aware of their spiritual beliefs and needs, and 67% reported that spirituality helped them to cope with psychological pain (D'souza, 2002). Furthermore, a study of 292 outpatients with cancer seen at the Northwestern Ontario Regional Cancer Centre, found that among all coping strategies inquired about,

prayer was used by the highest number (64%) (Zaza, Sellick, & Hillier, 2005). These studies were mainly based on surveys mostly conducted in one hospital, which cannot be representative of a larger population. The findings however are consistent with a growing body of research that suggests that people often turn to religion when coping with stressful events (Larimore, Parker & Crowther, 2002). This indicates that religious and spiritual coping is a common phenomenon in many countries in the West.

Previous research has also highlighted that people who are more spiritually and religiously involved have higher rates of overall well-being and life satisfaction and lower rates of depressive symptoms; lower rates of divorce and higher rates of marital satisfaction; and decreased rates of suicide, substance abuse, and antisocial behaviour (Leigh, Bowen, & Marlatt, 2005; Wolf, & Stevens, 2001; Worthington, Kurusu, McCollough, & Sandage, 1996).

Furthermore, research indicating substantial progress in the successful integration of spirituality and religion into clinical practice can also be found. Bonelli and Koenig (2013) conducted a systematic evidence-based review of studies published in 20 years (1990-2010). Among the 43 studies that involved religious interventions, thirty one (72.1%) found a relationship between level of religious or spiritual involvement and less mental difficulties (positive), eight (18.6%) found mixed results (positive and negative) and two (4.7%) showed a negative relationship.

All studies on dementia, suicide, and stress-related disorders found a positive association, as well as papers on depression (79%) and substance abuse (67%), respectively. There were mixed findings in schizophrenia studies; and bipolar disorder

studies indicated no association or a negative one. The review concluded that in areas of depression, substance abuse and suicide, religious involvement was associated with better mental health. There was some association in stress-related disorders and dementia, and insufficient evidence for bipolar disorder and schizophrenia. The findings are also consistent with Koenig's (2009) systematic review in which 476 of 724 quantitative studies (studies published in 20 years prior to the year 2000) reported statistically significant positive association between religion and mental health.

Koenig (2009) further highlighted that religious beliefs provide a sense of meaning and purpose in adversity that assists with psychological integration, and promotes a positive worldview that is optimistic and hopeful. Religion also provides role models in sacred writings that facilitate acceptance of suffering and give people a sense of indirect control over circumstances, reducing the need for personal control. Religion can also offer a community of support, both human and divine, to help reduce isolation and loneliness (Koenig, 2009). Transtheoretical aspects of spirituality, including acceptance, forgiveness, hope, prayer, and meditation can be beneficial when incorporated in therapy **(**Gorsuch, & Miller, 1999; Johnstone *et al.* 2012). In order to reveal potential sources of support for clients, it is also important to assess the influence of spirituality on their lives by exploring their history of religious and spiritual participation and experiences; and their current practices, beliefs, rituals, and community involvement (Bray, 2011).

This indicates an upsurge in research highlighting the importance of incorporation of spirituality and religion into therapeutic practice in recent years. Crossley and Salter (2005) however, argued that although there is an increased emphasis upon spirituality in

the psychological literature, concerns are still raised that issues relating to spirituality and religion are consistently overlooked within a therapeutic setting. The ethical complications of such integration have also been indicated as a potential barrier that will next be discussed.

2.2.4 Ethical Dilemma and Recommendations

Despite a seemingly well-established relationship between religion, spirituality, and mental health, the integration of spirituality into the process of therapy is not straightforward and ethical concerns may arise and result in dilemmas for both non-Muslim and Muslim therapists.

Some potential ethical concerns when using spirituality within the therapeutic process may include the issue of dual relationships (professional/religious), the risk of imposing religious values on clients, competency issues, and a bias towards addressing religion in therapy (Garzon, 2005; Gonsiorek et al, 2009; Richards & Bergin, 1997). Tan (2003) further highlighted some potential areas of concern: (a) the possibility of violating the therapeutic contract by focusing on the religious rather than therapeutic goals (b) maintaining the boundaries (c) overestimating competency to deal with religious issues when referral to religious leaders might be needed.

In order to address the above, a thorough assessment of clients' religious and cultural issues should first be made by the therapist in order to determine the appropriateness of integration of spiritual interventions (Tan, 2007; Walker, Gorsuch, & Tan, 2004). A strong therapeutic alliance should be established and proper informed consent procedures followed (Garzon, 2005; Hamdan, 2007; Richards & Bergin, 1997; Tan,

2007). A flexible approach and avoidance of the imposition of any religious values on the client is essential during therapy (Garzon, 2005). Tan (1994) further suggested that there should be an appropriate rationale for using a particular spiritual intervention. Furthermore, three guidelines for clinicians considering use of religious interventions have been suggested: (a) respect for the client's autonomy and freedom, (b) sensitivity to and empathy for the client's religious and spiritual beliefs, and (c) flexibility and responsiveness to the client's religious and spiritual beliefs (Garzon, 2005; Richards & Bergin, 1997). A need for supervision of such practice was also expressed (Carroll & Holloway, 1998; Gubi, 2007).

The current study has also attempted to explore obstacles that Muslim therapists might face when incorporating Muslim interventions into their therapeutic practice with Muslim clients. Furthermore, in order to ensure an ethical practice of such integration, therapists also need to engage with the context that might impact the way spirituality and religion is perceived by individuals from diverse backgrounds.

2.2.5 Religion and Spirituality in the Muslim context

The terms religion and spirituality may have different interpretations depending on culture, race and communities (Rassool, 2015). Whilst there may be a number of common themes such as God, meaning, purpose, value and hope, there does not appear to be a common definition that fully encapsulates spirituality and religion (Swinton, 2001). According to Koenig (2009), religion involves beliefs, practices, and rituals relating to the sacred: God or gods of a particular faith. Religion may also involve particular beliefs about life after death, spirits, angels, or demons and supernatural powers (Koenig, 2009). Spirituality on the other hand may be defined as an actualizing

tendency that may direct an individual towards love, compassion, meaning, hope, connectedness, transcendence, creativity, growth, and the development of a value system (Miller, 1999). In the western context, whilst religion may be related to spirituality, they are not interdependent since the term spirituality is used in a secular sense and has become generic in accounting for artistic creativity that may help an individual to transcend natural limits of personal being (Lines, 2006).

While there is sometimes difficulty in the synergy of religion and spirituality in the West, for most Muslims the two are considered inextricably linked (Rassool, 2015). Rassool (2015) has argued that in the Islamic context there is no spirituality without religious thoughts and practices, and religion provides the spiritual path for growth. This stance seems different from the Western construct of spirituality. Sermabeikian (1994) suggested that for Muslim clients religion and spirituality should be viewed as something that transcends dogma and institutions and something that is meaningful for them.

This difference in the interpretation of spirituality and religion has direct implications for therapy with Muslims as many mainstream approaches may incorporate spirituality in Western terms. For instance, CBT has incorporated spirituality into therapy. Spirituality however is addressed in the terms of meditation, and drawing upon the principles of mindfulness and yoga exercises (Coyle & Lochner, 2011). Mindfulness technique is used directed towards therapeutic outcomes rather than as a spiritual practice or as a means of addressing clients' spiritual concerns (Coyle & Lochner, 2011). This has limitations for Muslim clients who may require an in-depth exploration of complex spiritual and religious issues in therapy.

Fallot (2007) further highlighted that the religion and spirituality is perceived as different constructs by psychiatrists and psychologists in the West. For example, psychiatrists and psychologists affirm the importance of spirituality to a much greater degree than religion, suggesting that they may draw a sharper distinction between these realms (Shafranske, 2000). He further suggested that these differences raise the important question of cultural competency or spiritual competency of practitioners to understand and take into account the spiritual and religious realities of the people from different cultures and religions.

It can be argued that the notion of spirituality and religion is distinct in the Muslim context, and that should be taken into account to ensure an ethically sound practice so that an in depth exploration of spiritual issues can be facilitated.

2.2.6 Religious and Spiritual Coping amongst Muslims

The utilization of religious and spiritual coping practices amongst Muslims is a common practice. Khan (2006) in a cross- sectional study involving 459 Muslims from a diverse ethnic background in Ohio, found that the majority of their Muslim sample used prayer, Qur'anic recitation, and sought spiritual, religious and communal support when coping with distress. Yucel (2007) conducted a quantitative study at Brigham and Women's Hospital (Boston) with 60 Muslim adults and also found positive effects from Islamic prayer including Qur'anic recitation and supplication. The participants felt hope and comfort, with reduced stress and depression. Similarly, Loewenthal, Cinnirella, Evdoka and Murphy (2001) study examined the role of religious factors in coping with depression amongst different cultural-religious group in the UK. The questionnaires were administered with 130 Christians, 35 Jews, 33 Muslims, 18 Hindus, 15 other

religions (Sikh, Buddhist and New Age) and 56 Atheist university students. It was found that Muslims believed more strongly than other groups in the efficacy of religious coping methods for depression. They were most likely to say they would use religious coping methods and were least likely to say they would seek professional help for depression because they thought that religious coping strategies were more congruent with their religious belief system as compared to discussing their matters to an outsider.

Considering that religion and spirituality is a significant tool in the Muslim coping arsenal in times of distress psychologists have attempted to incorporate religious and spiritual beliefs and practices into therapeutic practice (Abdullah 2002; Abu Raiya & Pargament, 2010; Ahmed & Reedy, 2007; Haque, 2004b; Kobeisy, 2006). The next section will discuss these interventions in detail.

2.3 THERAPEUTIC INTERVENTIONS FROM MUSLIM PERSPECTIVES

Aspects of modern psychology (e.g. models of the self) and how they apply to mental health had started to emerge in the Islamic world as early as the 11th century (Skinner, 2010). Early Muslim philosophers such as Ghazali's (1986) theory of self provided a basis for the current therapeutic models from a Muslim perspective (Skinner, 2010). Currently, Muslim psychological models and therapeutic interventions are emerging, evolving and developing (Rassool, 2015). Muslim therapeutic models and interventions that can be incorporated in therapy will be discussed in three sections.

- Mental health beliefs and their relevance to therapy
- The Islamic model of self and its therapeutic implications
- Use of religious practices in therapy

2.3.1 Mental Health Beliefs and their Relevance to Therapy

Muslims' Mental Health Beliefs and Perception of Healing

Muslims have a broad range of spiritual, religious and cultural beliefs that are absolutely central to the way Muslims interpret the cause and development of their mental health difficulties (Farooqi, 2006; Utz, 2012). There is also a tendency to believe that psychological difficulties such as depression are caused by spiritual weakness or a failure to live in harmony with Islam; or could be caused by a lack of faith or failure to pray regularly (Ali et al, 2004). Mental health difficulties are also regarded as a way of atoning for sins or as trials and tests from Allah (Rassool, 2000). Kilani (2003) quoted the sayings of Prophet Muhammed (PBUH): "For every misfortune, illness, anxiety, grief or hurt that afflicts a Muslim, even the hurt caused by the pricking of a thorn, Allah removes some of his sins" (Mukhtasar Sahih Bukhari, no 1949; p 5) that also demonstrates the above.

Supernatural explanations for mental health difficulties are also widespread amongst Muslims. Utz (2004) discussed four possible ways in which Muslim may feel that they have been affected: by whispering (waswasa, doubt), magic (sihr), evil or bad eye (nazr which is a negative energy transmitted by a jealous person) and possession by a Jinn or spirit (Ali & Aboul-Fotouh, 2012).

In a study (Abu-Ras & Abu-Bader, 2008) about the perception of mental health difficulties, 98 per cent of survey respondents had agreed that life stressors were a test of one's faith; and other purported supernatural causes such as black magic, the evil eye and envy were reported by others to invoke a negative impact. Charms, prayers or rituals were used to counteract these. Eighty four percent of the respondents believed in

devil or Jinn possession for individuals with hallucinations, delusional beliefs and disorganised behaviour.

The findings were based on a non-random sample of 83 participants all from the one borough of New York, however, it can be argued that the concept of evil eye and spirit possession is not limited to any one region, culture or religious group and is present and accepted in many cultures (Spooner, 2004). Possession disorder, dissociative disorder and culture-bound syndromes are included in DSM-V (APA, 2013). Similarly, the temporary loss of awareness of surroundings and personal identity is classified by the International Classification of Disease (ICD-10; World Health Organization, 2015) as dissociative (conversion) disorder but also 'possession disorder'.

It is important that Muslim clients' beliefs about the cause of mental health difficulties is understood by practitioners, as unhelpful beliefs might need to be altered to facilitate change (Utz, 2012). Beside health beliefs about the cause of mental health difficulties there are religious and spiritual beliefs (e.g. patience and belief in life after death) that can be used for coping. The next section will discuss how these beliefs can be incorporated into therapy.

Therapeutic Implications

Muslims' religious and spiritual beliefs such as life after death, recalling the purpose of distress or finding meanings in sufferings, reliance on Allah and patience in times of difficulty can evoke hope and resilience in clients and facilitate healing (Abu-Ras & Abu-Bader, 2008; Hamdan, 2008). These beliefs can be utilised in therapy by a practitioner. Mehraby (2003) study for instance showed that Muslims' belief that all

suffering, life and death are derived from Allah gives comfort and strength that aids the healing process in accepting grief and loss; the relatives of the deceased person are urged to be patient and accept Allah s decree.

Mehraby (2003) supported her arguments by two case studies of Afghan and Kurdish-Iraqi refugees who had lost most of their family members during the war in their home countries. Both clients expressed intense grief reaction, depression; and anxiety mainly associated with prospect of punishment for not accepting God's decree and for being impatient and grieving for the loved ones for many years. In therapy, the therapist validated their feelings and normalized by narrating the story of prophet Muhammed (PBUH), the enormous number of family members that he had lost during his life and his grieving for his mother and wife Khadijah years after their death. This helped the clients to strengthen their beliefs about Allah's mercy and forgiveness disputing the beliefs about punishment; and enhanced their hope that God would reward their suffering in the next life.

The above demonstrates that Muslim beliefs such as life after death, reliance on Allah and cultivating patience can facilitate healing by enhancing hope and resilience in Muslim clients. Furthermore clients' unhealthy beliefs such as believing that they are being punished can be challenged by the practitioner and altered to bring about more healthy attitudes. It is also crucial for therapists to accept, respect and validate the beliefs or experiences of Muslim clients. A therapist who cannot understand or account for these dimensions may not comprehend the client's reality, which may hinder the therapeutic alliance and process of change (Hamdan, 2008). These beliefs should also be taken into consideration when formulating the appropriate therapeutic plan because

Muslims who give a spiritual explanation to the cause of their distress may also look for spiritual healing practices (Abu-Ras & Abu-Bader, 2008; Utz, 2012).

The next section will discuss the Islamic notion of self and how this can be incorporated in therapeutic practice.

2.3.2 Islamic Model of Self and its Therapeutic Implications

Islamic Notion of Self

The Islamic notion of self is considered the most significant area in therapy whilst working with Muslim client (Skinner, 2010). The model of self seems to provide a basis for any therapeutic work with Muslim clients in therapy, it will therefore be discussed in depth.

From an Islamic perspective, the self is represented in the following forms: the spiritual heart (*Qalb*; a symbolic term; heart beyond the physical organ), the soul or spirit (*Ruh*), and the drives (*Nafs)*. The soul or spirit (*Ruh*) refers to a connection with the Divine and inner heart (Haque, 2004b). The spiritual heart (*Qalb)* and the drives (*Nafs)* have a significant role in the explanation of mental health and healing, the next section will explore that further.

The Heart (Qalb)

In Islam the heart (Qalb; a symbolic expression) is considered the most important aspect of self, due to its role in the personal and spiritual development of an individual (Haque, 2004b). Olatoye (2013) in a more recent study highlighted that from an Islamic perspective, the heart is the center of feeling, emotion, drives, aspiration and intentions

which has also been validated by scientists in the West as researchers have argued that the 'heart' may actually be the intelligent force behind intuitive thoughts and feelings (Armour, 1991; Frampton, 1991).

The Qur'an has identified several negative emotions, termed as 'diseases' of the heart such as acts of jealousy, greed, lust, harmful speech and showing off, which may be linked to mental health difficulties (Deuraseh & Abu Talib, 2005; Haque, 2004a). In order to achieve mental health it has been suggested that Muslims should strive to purify their hearts from these negative emotions through spiritual means entailing prayer, trusting in Allah and seek His protection (Frager, 2013). The state of the heart (Qalb) may be interlinked with stages of Nafs described below.

Nafs

The Nafs refers to desires and wishes. There are three levels of the Naf: Nafs al-Ammara (The Nafs driven by desires), Nafs al-Lawwammah (the Nafs that blames) and Nafs al-Mutma'innah (the Nafs at peace) (Deuraseh & Abu Talib, 2005). These three represent the stages in the process of development, refinement and mastery of the Nafs (Deuraseh & Abu Talib, 2005).

Developing Models of Therapy

Based on Islamic notion of self, Skinner (2010) proposed a model of therapy that takes several components of self including the heart, the drives (Nafs), the intellect (Aql) and the body. Healing is seen as holistic and comprises physical, psychological or spiritual dimensions (Skinner, 2010). The functioning of self is viewed as along the spectrum or continuum which is opposite to the notion of Cartesian splits between mind and body or

mind and spirit (Skinner, 2010). Skinner (2010) argued that it is important to recognise whether a state of anxiety for instance is physiological primarily caused by an unsuitable diet (for example an excess of caffeine) or psychological, or spiritual or a compound of these.

Skinner (2010) highlighted that this formulation is at the heart of the therapeutic process as he criticises the efficacy of mainstream psychology and Western psychiatry, which can result in crudely simple or incomplete diagnoses and can ignore or pay little attention to the holistic and personal meanings of distress. Skinner (2010) further argued that many states of low mood have been explained by the disease category of depression under the guidelines of the National Institute for Clinical Excellence (NICE). The cause was often thought to be biological with cognitive dysfunctions, and was therefore treated with anti-depressants and cognitive behaviour therapy whereas low mood can be caused by remorse, which may be cathartic and necessary for the process of growth for Muslims.

Within Islamic thinking, the process of change from the self being driven by Nafs al-Amara to the state of remorse (Nafs al-Lawwama) is viewed as part of a journey back to the inner heart. He therefore argued that treating Muslim clients with anti depressants and CBT gives no meaning to the experience and can stunt personal growth. Skinner's (2010) model is in line with Alladin's (1993) ethnomedical model, in which he stressed that the eastern healing tradition is holistic; therefore Muslim clients should be treated in the totality of body-mind and spirit. It can be argued that Skinner's (2010) model corresponds with Muslims' holistic understanding of mental health and healing, however the model has not been supported by any clinical evidence.

The model of 'Islamic counselling' that Dharamsi and Maynard (2012) proposed is comparable with Skinner's (2010) model with an increased emphasis on *Tassawuf* (Sufism), which perceives presenting problems as a means towards self development. It is through self reflection that clients are able to heal themselves and to identify their highest potential. They have added a case vignette of a client with anger issues and guilt following the breakup of his marriage. His presenting problem were attributed to conflicting levels of *Nafs* by the therapist who suggested that his anger came from his sense of powerlessness and that his expectations from his marriage had not been met. This was interpreted as Nafs al-Ammara: the commanding self that is primarily reactive.

Later therapists suggested that another level of self: Nafs al-Lawwamma was emerging in client marked by his guilt as he started to realise his responsibilities towards his wife and marriage. The therapist viewed the client's powerlessness, his love for his wife, his anger, limitations, and struggle to transcend them as all facets of the client's reality and invited the client to reflect on them as a potential for growth. The therapist further facilitated change by helping the client to accept the very paradoxical nature of the struggle between worldly drives (Nafs) and the potential to transcend them.

This model of self is however, not comprehensive and only provides an outline for further development and refinement. It also did not shed any light on how the role of the therapist and therapeutic relationship was perceived by the client or the therapist and on any psychological benefits of that relationship. Keshavarzi and Haque (2013) more recently has outlined an Islamic therapeutic model which highlights the role of a spiritual healer (shaykh) that resembling the role of modern therapist.

According to Keshavarzi and Haque (2013) a person might seek out a spiritual healer for their spiritual healing or help with depression, anxiety or a host of mental health difficulties. The sheikh who is trained in of has some knowledge of the spiritual path; establishes a strong connection with his disciple and the disciple puts faith and trust in his healer. This bond facilitates empathetic understating, catharsis and insight into the individual's inner and interpersonal conflicts (Farooqi, 2006). This attachment facilitates positive change and hope and motivation for healing according to this model. The shaykh might help the individual to choose spiritual techniques which is similar to behavior concepts of shaping and behaviour reinforcement (Keshavarzi & Haque, 2013). One has to go through tribulations and painful purification regarding impulses and drives (Nafs) for a pattern of change to occur. Once a person completes the spiritual (or healing) path through the integration of faith and a spiritual lifestyle, displaying behavior that reflects social and personal change and growth (Abdullah, 2007) he or she is no longer as dependent on the *shaykh*, and the acquisition of the person's experiential education has been completed.

This model is also exploratory and outlines the role of therapist highlighting some parallels with the modern therapeutic relationship and psychological benefits of this type of relationship, however it provides no empirical evidence of these kinds of relationships which might be translated into therapeutic practice with Muslim clients. The current study will make an effort to explore some of these questions regarding the nature of therapeutic alliance between a Muslim client and a therapist through the use of Muslim interventions.

The next section will focus on the religious and spiritual practices that are being used in therapy with Muslim clients in the UK.

2.3.3 Use of Religious Practices in Therapy

Use of Prayer in Therapy

Prayer has been defined as "thoughts, attitudes, and actions to express or experience connection to the sacred" (McCullough & Larson, 1999; p 86). According to Stolley, Buckwalter, and Koenig (1999), prayer may be the most profound religious coping behaviour and can support the use of other positive coping methods. Besides five obligatory prayers, different forms of prayer such as recitation of the Qur'an, Supplication (Du'a), and religious invocation (Dhikr/Zikr; remembrance of God) can be practiced by Muslims in distress for healing (Ali & Aboul-Fotouh, 2012; Utz, 2012).

Utz (2012) further highlighted that Muslim clients may ask religious leaders or expect Muslim therapists to perform 'ruqyah' (reading certain Qur'anic verses for protection and healing) a technique for healing purposes. Research shows the effectiveness of prayers, for example the five daily prayers (Salah; Sayeed, & Prakash, 2013), Ziker (invocation; Majid, 2001), and the recitation of Qur'anic verses, in curbing depression in Muslims (Suhail, & Ajmal, 2009).

The Cinnirella and Lowenthal (1999) study highlighted some underlying beliefs of Muslim clients with regards to the relationship between prayer and their mental health. Muslim clients with both depression and schizophrenia felt that a belief that Allah is listening to their requests in their prayers gave them a sense of comfort. Furthermore, prayers were perceived to be a mean of gaining inner knowledge about the self and seen

as almost a form of self-administered therapy and such as something that carries value because it maintains the feelings of control and self efficacy.

Making Supplication (Du'a)

Supplications have been used by Muslims to ask for forgiveness, the mercy of God and to seek protection. Hamdan (2008) suggested that supplication if performed with sincerity can dispel worry and bring comfort, converting distress into calm. Supplication can also be performed to seek protection and refuge from distress. In therapy this can be performed at the beginning of the session to seek help and protection from Allah or it may be performed after a prayer such as after recitation of Qur'an.

Dhikr: Remembering Allah

Dhikr/Zikr Allah (remembering God) is defined as "the flawlessness of recognition" (Rahman, 2014; p 5). Awan (2003) indicated that this is based on meditation techniques practiced by early Islamic Sufis that purifies the Qalb (spiritual heart) and helps to focus attention inwards (Rahman, 2014). This might include chanting of Allah's 99 names, which represent His qualities, accompanied by rapid and deep breathing (Suhail & Ajmal, 2009). Zikr therapy has been found to be effective in reducing preoperative anxiety (Mardiyono, Songwathana, & Petpichetchian, 2011), insomnia (Purwanto & Zulaekah, 2007), and physical and psychological distress (Songwathana, 2009).

The Hamdan (2008) study has shown that the 99 names of Allah and their meanings when incorporated in therapy can have a therapeutic impact. For instance, His name Ar-Rehman means: The all Merciful, Ar-Raheem: The most Compassionate, Al-Wudood: The Loving, Al-Ghafaar: The forgiving, and so forth (Hamdan, 2008). An

understanding about the attributes and meanings of Allah's names can help Muslim clients alter their counterproductive beliefs. Through her case study vignette, she has shown that if a Muslim client believes that he has been punished by God, drawing his attention towards Allah's name: Ar-Rehman can help the client to contemplate on His Mercy and alter his counter-productive cognitions of being punished and Zikr of Allah's name can elicit calmness and hope. Hamdan (2008), however, urged that there should be more research as to how the Zikr could be used more effectively in the therapeutic process.

In a more recent study, Abdul-Hamid and Hughes (2015) draw attention to the healing capacity of Dhikr in trauma and stress, and argued that the ritual movements performed during Sufi Dhikr may involve a form of Bilateral Stimulation (BLS), which is why this intervention can be effective when used in therapy. They further call for more research to investigate the Sufi Dhikr element being incorporated into a modified EMDR protocol for Muslims anticipating this will give EMDR more acceptance by Muslim clients.

Ruqyah

Ruqyah is a form of payer that can be performed by recitation of verses of the Qur'an or supplications for healing purposes (Utz, 2012). It can be performed by a client himself, a spiritual healer or a therapist trained in this technique. Relevant parts of the Qur'an may be recited over water, which the individual drinks, or blows it (whilst reciting the Qur'an) onto the palms of the hands, then rubbing it onto the body (Rassool, 2015). Eneborg's (2013) study more recently reported that the Ruqya as a traditional healing practice had gained popularity amongst young Muslims in some parts of London in

recent years. The study found that elements of this traditional healing practice incorporated in mainstream therapy made it more appealing to the new generation of Muslims in the UK. It is reported to be beneficial for psychological difficulties which are attributed to evil eye, possession of jinn, envy and black magic.

2.3.4 The Use of Prayer in Therapy in the West and Some Ethical Issues

Prayer in counselling may arguably be considered an unorthodox practice, however, it has consistently been used in the West. Gubi (2004) conducted a survey into the extent of the use of prayer in counselling and found that 51% of BACP accredited counsellors, and 91% of Churches' Ministerial Counselling Service (CMCS) approved counselors have used or use prayer either covertly (without engaging the client directly) or overtly (with the clients' engagement) in their counselling practice. These figures suggest that spirituality has been a part of many counsellors' practice in the West (Gubi, 2002).

Gubi (2001) has argued that prayer can enhance one's locus of evaluation, fostering authenticity and self-worth. Johnson (1945) states that prayer results in "an awareness of needs, emotional catharsis, peace of mind, broader perspective on problems, social responsiveness, joy, gratitude, acceptance of one's losses, loyalty, perseverance and integration of personality" (p 122-123). Kaye and Robinson (1994) state that prayer enables the perception of forgiveness from God and the reframing of experience, a sense of meaning, purpose and value to one's existence.

Although prayer can be psychologically transformational, the integration of prayer into counselling is perceived to be complicated. Gubi (2007, 2009) studies reported many hurdles counsellors may experience while using prayers in therapy. For instance,

interviewees felt that prayer had the risk of creating unhealthy transference issues, dual relationship issues and role-boundary confusion. The findings also revealed that some interviewees were aware of the potential undermining of the client's autonomy if the therapist's values and beliefs are conveyed through prayer. However, Gubi (2002) argued that prayer need not be any more problematic to integrate in therapy than any other intervention, as long as it is in accordance with clients' needs. He further highlighted the importance of supervision and informed consent.

Mainstream therapy and Muslim healing tradition both incorporate prayer into therapy; there are some other shared features between mainstream approaches and Muslim interventions that will be discussed next.

2.3.5 Similarities with Mainstream Therapeutic Approaches

Parallels with Psychodynamic Approach

The three stages of Nafs have limited equivalence with Freud's (1992) psychoanalytic theory of personality: The Id, the ego and super ego (Abu-Raiya, 2014). The Nafs al-Ammara can be expressed as the Id which is driven by the pleasure principle and strives for immediate gratification. Nafs al-Lawwammah has some equivalence with ego and super ego. This is the stage of conflict and the stage of decision-making in which good actions win a majority of the time (Abu-Raiya, 2014). Nafs al-Mutma'innah is the highest and purest stage, which perhaps Freud never explored in detail (Abu-Raiya, 2014).

The Islamic notion of self is not, however, deterministic as in psychodynamic theory, because human beings are seen as essentially autonomous and have free will, intentions,

choices and responsibility for their actions according to the Islamic view of human nature (Inayat, 2005). Thus, these parts (of Nafs) can be in conflict with each other from time to time. It is believed that human beings have the innate potential to transcend the lower levels of self and a tendency towards reaching their highest potential (Dharamsi, & Maynard, 2012). This can be likened to Maslow's (1964) idea of self-actualization, and Rogers' (1959) idea of growth potential which he believed to be an innate human drive that all individuals seek to acquire. Islamic philosophy, however, emphases the idea of self-realization, and an inward journey rather than self-actualization, as one never actually reaches perfection but tries to come as close as possible (Keshvarzi & Haque, 2013).

Parallels with Jungian Psychology

Aspects of the Islamic notion of self are similar to aspects of Jungian psychology in that the inner self contains inspiration in a spiritual sense, which can then be transformed into understandable images in the form of dreams or perhaps visions (Skinner, 2010). This is similar to Jung's archetypes (Jung, 2001). Skinner (2010) viewed the concept of the 'inner heart' (Qalb) as similar to what Jung calls the 'depth unconscious' and both direct a fundamental aim of therapy, which is to access this core part of the self when it has been shut off and disassociated from consciousness.

Parallels with Existential Philosophy

Loufty and Berguno (2005) compared the thoughts of existential philosopher Kierkegaard (1989) who wrote extensively on religion, and Muslim Sufi philosopher Ghazzali (1986) whose work on self and personal growth is considered as being pioneer. Several common themes were discussed, including emphasis on existential insight and a search for deeper understanding of self and reality, as well as conceptions

of truth and self-liberation. Both sought to deepen the direct relationship with God as well as emphasising the importance of the inward journey that leads to the attainment of this relationship. Differences were also noted, including the major role of hope in one's development as described in Sufism, contrasted to the concern with suffering and despair in existential thinking.

Thus, there seem to be parallels and similarities between aspects of Muslim healing practices and mainstream psychotherapeutic approaches; and psychological models including psychodynamic, Jungian psychology, humanistic psychology, existential philosophy and CBT. Muslim psychologists like Badri (1997), Zaidi (1979) and Haque (2000) have maintained that mainstream psychology is not sufficient for Muslim clients' spiritual and religious needs. They argued that the Islamic notion of spirituality is distinct, therefore Muslims should be offered a therapy based on Islamic healing traditions. However, none of these psychologists has developed an approach or model of Muslim therapy. Recently developed models based on Muslim therapeutic perspectives are limited in their theoretical and practical constructs and only provide an outline needing further development and refinement (Rassool, 2015). Hence, more research is needed.

2.4 CRITICAL NOTES ON PREVIOUS RESEARCH

Despite an increase in research on Muslim mental health in recently years, most research on the usefulness of Muslim therapeutic interventions is descriptive in nature and empirical studies are still scarce (Abu-Raiya, 2013; Richards & Worthington, 210). Areas where there is a dearth of existing research will next be identified so that further research can be suggested to address this.

Most studies conducted to raise understanding of Islam and Muslim mental health have only provided a 'birds-eye view' (Abu-Raiya & Pargament, 2011). Although having a basic understanding of Muslim cultural and religious beliefs and values is crucial for therapists but often not sufficient to meet the complex needs of Muslim clients in therapy. Rossool (2015) warned therapists that having only a basic level knowledge of Muslim beliefs and overly simplified definitions of Islamic values and traditions can lead to stereotyping, bias and prejudices in therapy. Thus more in-depth knowledge is required that can be generated through further research.

Furthermore, early research into Muslim mental health has identified a sharp line of demarcation between mainstream approaches and Muslim healing tradition. For instance, Alladin (1993) criticised the reductionist approach of traditional psychiatry and mainstream psychological approaches for isolating the body from the entire being. He stressed that CBT only focuses on thinking and cognition and therefore ignores the spiritual dimension, whereas the Muslim healing tradition is more holistic and takes mind, body and spirit into consideration. This criticism is outdated since cognitive behavioural therapy is no longer limited to cognitions; instead CBT incorporating spiritual and religious aspects has been very useful for religious clients (Beshai, Clark & Dobson, 2013; Coyle & Lochner, 2011). Johnson and Ridley (1992) tried to incorporated Christian religious rationales for imagery procedures and enabled clients to question irrational beliefs, using Bible texts.

Abu-Raiya, (2013) however, argued that research in the psychology of religion has focused almost exclusively on Christian populations and largely neglected people from other traditional faiths, Islam in particular. However, there are studies indicating a

successful integration of Islamic faith in to mainstream therapy. Hamdan (2008) study for instance indicated that there are several beliefs and cognitions within the Muslim faith that can be integrated into CBT. Cognitions such as focussing on the blessings of Allah, trusting and relying on Allah' life after death belief, recalling the purpose of distress or finding meanings in suffering can be used to counter maladaptive thoughts related to hopelessness and feeling overwhelmed with life, and can enhance healing and growth.

It can be further argued that despite an emerging body of research in recent years systematic, rigorous, and large-scale scientific psychological research on Muslims in therapy has been particularly sparse (Abu-Raiya, 2013). The empirical research has several limitations. Much previous research on Muslims' mental health and Muslim interventions has been conducted within a positivist-empiricist paradigm. Songwathana (2009) conducted a literature review to examine the relationship between Islamic religious practices as a relaxation method and psychological and physical wellbeing. Methods of conducting Islamic relaxation were described in two categories: 'original religious methods' including Zikr or remembrance of Allah, prayer and recitation of the Qur'an and 'religious modified psychotherapy' such as use of modified cognitive therapy with Islamic tenants. In the fifteen publications, the majority of studies used in the review were Quasi-experimental design (n=9), correlational studies (n=3) with a few randomized control trials, all showing that they had used at least one psychological or physiological outcome measure. One was a reviewed study and two were reports on books regarding the use of Islamic relaxation to enhance psychological and physiological outcomes. Participants in the twelve reviewed studies were adults in Middle East and USA.

The review showed the effectiveness of original Islamic relaxation methods such as prayer and Zikr in enhancing happiness and physical health (Abdel-Khalek, 2007), alleviating anxiety and depression among Muslim students in Iraq (Abdel-Khalek, 2007), in Kuwait and USA. Prayer also enhanced coping among cancer patients and improved immunity in high school students. Zikr therapy as 'original Islamic relaxation technique' was effective in dealing with psychological problems such as preoperative anxiety and insomnia. Similarly, 'modified cognitive therapy with Islamic tenets' was effective in reducing anxiety, depression, and dealing with bereavement issues. There were however inconclusive psychological and physiological outcomes for reciting the holy Qur'an as a relaxation intervention.

Although the above demonstrates the usefulness of Islamic interventions as a relaxation method on psychological outcomes, there were limitations. The focus of the review was on Islamic interventions as a relaxation technique. Syed (2003) study in the review showed recitation of the Qur'an used for mindfulness and palliative care, but found no positive impact on relaxation. Therefore a comprehensive insight into the usefulness of these interventions was not provided. Furthermore, the sample in the studies was limited to Muslims in the Middle East and USA, making it less relevant to Muslims living in the UK. The researchers of the review also indicated inconsistency in the measures used in studies to assess psychological and physiological outcomes, leaving their validity questionable. Furthermore, they provided no rationale for focussing mainly on quantitative studies for the review.

It may be due to the factor that much previous research on Muslims' mental health is predominantly quantitative (e.g. Abdel-Khalek, 2007; Khan, 2006). Coyle (2008)

argued that there has been emphasis on quantitative methodology even when this framework does not seem relevant in exploring topics such as religion and spirituality. He attributed this to a historical tension between psychology and religion and the consequent need for religion to establish credibility within the field of psychology. This could also be due to the dominance of traditional designs and quantitative analysis, or related to research questions chosen (Coyle, 2008). Although quantitative studies offer an insight into the mental health of Muslim clients, they lack the richness of data obtained from qualitative methodologies. Quantitative studies may also fail to explore the nuances that can govern the success of the therapeutic relationship when Muslim interventions are being used.

With this in mind, a literature search for qualitative papers investigating Muslim mental health and healing practices in counselling was conducted and produced limited studies; the most relevant study was Weatherhead and Daiches, (2010). This qualitative study used thematic analysis of semi-structured interviews conducted with eighteen Muslims living in the UK. It was distinct as it used a heterogeneous Muslim population and provided a rather comprehensive picture of Muslim clients' perceptions of mental health and healing. The study explored seven themes: 'cause', 'problem management', 'relevance of services', 'barriers', 'service delivery', 'therapy content', and 'therapist characteristics' providing a descriptive account of participants' understanding of key processes in the generation of mental distress and potential paths to healing. Findings showed that barriers were similar to previous research including fear of being misunderstood by a therapist lacking understanding of Muslim culture and religious beliefs and being stereotyped (Ali et al, 2004). Coping with difficulty through patience and trust in the divine amongst Muslims was also reported.

The study was limited by sample size and may not be viewed as representative of the Muslim population as a whole in the UK. However the diverse make-up of the sample and richness of data may counter this limitation. The study found that participants were positive about help seeking and reported that therapy and Islamic beliefs and practices complemented one another. Respect for and understanding of a client's religious beliefs was seen as essential for a positive therapeutic relationship. However, the study only provided insight into clients' perspective of this phenomenon. The present study has explored Muslim therapists' perception of Muslim mental health, therapeutic practices and its relation to therapeutic alliance and therapy outcomes. Coyle (2008) further suggested that phenomenological qualitative research is best when the research questions are related to exploration of participants' meaning-making and focussing on context in all its complexity. For this reason IPA was chosen for the current study (see methodology chapter for further rationale for the method).

2.5 CURRENT RESEARCH

The current study addresses the gaps in the literature about lack of research on therapeutic interventions from Muslim perspectives. Knowledge gained from research could provide information on how these interventions can be utilized to help Muslim clients in therapy. Muslim therapists could use the knowledge to improve interventions designed for use with Muslims. The findings may further help therapists to focus on developing suitable interventions based on Muslim perspectives, developing training courses in order to bring a wider spectrum of psychological literature from diverse perspectives into the counselling psychology field (Leung, 2003). The use of these interventions may also be helpful in engaging Muslim clients in therapy and to reduce drop out. Students studying psychology might benefit from increased exposure to a

wider spectrum of literature within psychology, incorporating other belief systems, enabling them to think globally and encouraging them to read more widely (Leung, 2003). It can also be helpful for supervisors.

The present study addresses the following research questions:

Question 1: How are Muslim therapeutic interventions understood, experienced and administered in therapy by Muslim therapists with their Muslim clients?

Question 2: How do Muslim therapists decide the suitability and usefulness of a Muslim therapeutic intervention for a Muslim client in therapy?

Question 3: What kind of challenges, if any, Muslim therapists encounter in the application of such interventions, and in what ways these interventions can contribute to counselling psychology?

3. METHOD

This chapter will explain the methodology adopted for this study. It will outline the rationale for using qualitative research, the epistemological underpinnings of the methodology and why it was suitable for this particular study. The method will also be discussed including the design, participants, procedure, data analysis, trustworthiness and ethical issues.

3.1 APPROACH

3.1.1 Rationale for Qualitative Research

Like quantitative studies, qualitative research employs rigorous methods of sampling, data collection and analysis within a framework of scientific inquiry; however, it typically operates from a different set of assumptions, and therefore the research is approached from a different angle. For instance, qualitative researchers may try to understand the participants' perspectives on particular phenomena and how they construct meaning regarding those phenomena (Hanson, Balmer, & Giardino, 2011). A qualitative approach is compatible with the constructive-interpretative philosophy that underpins the exploration of this study's overall enquiry into therapists' experience of using Muslim therapeutic interventions with their Muslim clients.

Social constructionism is a postmodern philosophical movement that challenges the assumptions of modern psychology about universal truth and attaining the objective realities, through its twin emphases on the social and linguistic invention of knowledge (Gergen, 1985; 2001). Constructionists assert that reality is constructed within an individual, rather than it being an externally singular entity as is suggested by the positivist paradigm of quantitative research (Gergen, 1985; Ponterotto, 2005; Smith,

2015). The constructionist approach also highlights that an objective reality cannot be partitioned off from the "person (research participant) who is experiencing, processing, and labelling it" (Ponterotto, 2005; p 129), consistent with the aim of this study to capture participants' unique experiences of the phenomena under investigation.

The constructivist stance espouses a hermeneutical approach, which suggests that meaning can only be uncovered through deep reflection (Ponterotto, 2005; Schwandt, 1994; 2000). This reflection can be facilitated by the interactive dialogue between participant and researcher, through which the hidden meaning can be brought to the surface (Ponterotto, 2005). According to social constructionists, knowledge is a product of social consensus. Therefore the researcher and participant co-construct the findings through their interactive dialogue and interpretation. This is also relevant where the researcher is also a Muslim therapist and has knowledge of Muslim therapeutic interventions, which might have played a significant role in the process of conducting and analysing the research (see Critical Appraisal for further reflections). Thus, Interpretative Phenomenological Analysis (Smith, 1996) was chosen. The purpose of this study is both exploratory and interpretative, and thus best accomplished using a qualitative paradigm and a small number participant design allowing an in depth analysis (McLeod, 1994; 2001; Ponterotto, 2005) which is also relevant to IPA.

3.1.2 Theoretical Underpinning

Interpretative Phenomenological Analysis (IPA) with its theoretical underpinning in phenomenology, hermeneutic interpretations and idiographic perspectives on engagement with subjective experience and personal accounts, was considered to be the most appropriate form of analysis for this study.

Smith (2004) highlighted that phenomenology is concerned with the meanings through which individuals construct their realities. IPA's first aim is therefore to enable the researcher to try to understand the participant's worldview. According to Husserl (1927), the researcher attempts to bracket previous understandings, past knowledge, and assumptions about the phenomenon, so as to focus on the phenomenon in its appearing. However, Heidegger (1962) argued that it was not possible, even if desired, for researchers to detach themselves fully, therefore bracketing by no means implies a disengaged, objectivist stance towards analysis but facilitates reflective awareness of participant's accounts to begin a process of separating out what belongs to them rather than the participant. It is this latter theoretical perspective of Heidegger that IPA draws upon.

Hermeneutics proposes that it is the interpretative framework through which the world is understood. The second aim, therefore, of IPA involves a two-stage interpretation process (a double hermeneutic) where participants try to make sense of their world, while the researcher tries to make sense of the participants' trying to make sense of their world (Smith et al, 2009). This process helps to provide a conceptual and critical commentary upon the participants' personal meaning-making activities.

Idiography, the last characteristic of IPA, is concerned with the particular (Shinebourne, 2011). This is in contrast to psychological theory that is 'nomothetic', and makes claims at the group or population level, trying to establish general laws of human behaviour (Smith et al, 2009). IPA's commitment to the particular operates on two levels. Firstly, there is a sense of detail and depth of analysis. Secondly, it draws upon understanding of how particular experiential phenomena are understood from the perspective of

particular individuals, in a particular context (Larkin, Watts & Clifton, 2006). This central aspect of IPA maintains sensitivity to each person's unique story on one hand and draws attention toward its relational aspect on the other.

3.1.3 Epistemological Positioning

From a construction-interpretative epistemology, this research is inextricably bound to me as the researcher. My experiences from personal, professional and academic life are therefore woven through its fabric. Adopting a phenomenological stance requires reflexivity as the researcher adopts an open and non-judgemental approach to focus on the phenomenon in its appearing, i.e. Muslim therapists experience of using interventions from Muslim perspectives which is the aim of the current study. As IPA analysis is interpretative also, it is important that the researcher is positioned so that the reader can get a sense of the extent to which her beliefs, expectations and meaning making system have influenced the process of conducting the research, interpretations and analysis. Being a Muslim and a mainstream therapist traditional healing practices and conventional therapy practices are both central to my identity as a whole; this research was undertaken motivated by a desire to understand the experience of integrating traditional practices into therapy when working with Muslim clients.

As a researcher I was also interested in contributing to the interpretative process of the analysis by using my existing knowledge and experience of Muslim healing practices which is also encouraged in IPA (see chapter 6: Critical Analysis for further reflections). A researcher in an IPA study has an active role; and interpretation is double hermeneutic, where the process of accessing experiences shared by the participant can become intertwined with the perception of the researcher.

IPA also captures the in-depth analysis of a participant's experiences. IPA enables a detailed examination of one participant's account at a time until a level of gestalt is obtained. The researcher then moves on to the next case (Smith, 2004). As discussed earlier, research on Muslim therapeutic interventions is limited. This study has employed IPA as the research method so that it will help to obtain detailed descriptions and explanations of the phenomena, which IPA is capable of providing (Hefferon, & Gil-Rodriguez, 2011; Willig, 2013).

3.1.4 Why IPA versus Alternative Methodologies

IPA was chosen over other research methods for several reasons. The aim of this study was to explore the experience of Muslim therapists using Muslim therapeutic interventions, and to develop an understanding and gather information on such interventions by examining in depth experiences of participants. Such detailed descriptions cannot be gained through the use of questionnaires alone as it is done in quantitative research.

IPA fits well with the research question as its idiographic nature acknowledges the value of each participant's viewpoint, and its reflective interpretive stance does not claim that participant's experiences are a fact or a truth (Smith et al, 2009). It differs therefore from generalizing the findings and rather focusses on the perspective of particular individuals, in a particular context (Larkin et al, 2006; Ponterotto, 2005). Participant's experiences may relate to those appearing in other studies. Equally, analysis may uncover something, which is new to counselling psychology which may provide a basis for further research to develop current interventions, adapting models and techniques appropriately.

This approach differs from grounded theory (GT) since GT facilitates the process of "theory generation" using an iterative process to explain within and between participants' accounts (Willig 2008; p 34). IPA was chosen for the study as the aim was to explore the detailed experiences of participants using Muslim therapeutic interventions allowing meaning to emerge, whereas grounded theorists try to develop a model or a theory of that particular phenomenon (Charmaz, 2012; Wertz *et al,* 2011). This also encouraged the use of IPA because of its focus on ideography, rather than trying to offer a wider conceptual explanation of a phenomenon (Smith et al, 2009). Hence, IPA was given preference over grounded theory for the current study.

Similarly, 'focussing' on language and interactions between participants and researcher was not the primary aim of this study, hence discourse analysis and discursive psychology were therefore not chosen for this study. During discourse analysis the researcher analyses patterns of language on the understanding that the researcher must 'get behind' what people from different backgrounds really mean from their utterances (Jorgensen & Phillips, 2002). For the purposes of this study, however, IPA is used, which tries to interpret how participants are making sense of their experiences 'in that moment' rather to uncover the reality behind the discourse.

Furthermore, thematic analysis was considered, which, as defined by Braun and Clarke (2006) is a method of "identifying, analysing and reporting patterns within data" (p 79), however, the focus of the current study was to explore the richness of individual meanings, which would not be possible by using thematic analysis only. Thematic analysis is, however, the first order interpretation process of this study, which then goes further and moves away from the descriptive experiences of the participants, to a greater

emphasis on interpretative meanings. The researcher can then be more critical and conceptual about the participants' individual sense making experiences (Larkin et al, 2006).

3.2 DESIGN

Due to its commitment to a finely textured analysis, an IPA study can generate highly intensive knowledge by a small number of participants (Larkin et al, 2006). Six participants were interviewed in this study, as Smith et al. (2009) suggested that between four and ten participants is a reasonable sample size for a doctoral level research project using IPA. However, the proposed sample size was only confirmed after analysing that there is uniformity in the views expressed by the participants and that no new themes were emerging. This was in line with Patton's (1990) suggestion to review the participants' number upon completion of the interviews. A small number size can be seen as a potential limitation to the study, although well debated in previous research; participants were interviewed in-depth about their experiences. As the aim of this study was to investigate in-depth experience of participants, a small homogenous sample was necessary (Smith et al, 2009).

3.2.1 Participant Selection

The participants for this study were recruited via opportunity sampling (a non-probability sample drawn from a population convenient to the researcher), and snowball sampling or chain referral sampling (Marshall, 1996). Although suitable to obtain a homogeneous sample, which IPA requires, an opportunity sample had the disadvantage that transferability of the findings from such a sample may be limited. However, due to the idiographic stance of IPA, transferability is bound to lose its importance in a

traditional sense, as participants represent a perspective rather that the population in an IPA study (Smith et al, 2009).

Two participants were identified using snowball sampling referred by existing participants who used their own networking to provide contacts who might be potential participants and met the inclusion criteria for the investigation (Goodman, 1961). This has a potential risk of community bias and reduces the chances of transferability of the findings. This was however, less of a concern in the current study as IPA was deliberately chosen for its idiographic features.

An advertisement text (appendix 3: contact sheet) containing the relevant details about the study and the inclusion criteria was emailed to the members of the British Psychological Society (BPS) and UK Council for Psychotherapy (UKCP) by identifying their Muslim names from the psychologist/therapist register. A total of thirty-two individual requests were made. The Society of Existential Analysis and British Association for Counselling and Psychotherapy (BACP) were also contacted, but no permission was granted to forward the research participation request due to a research participation commitment limited to their own members. The Muslim counselling/psychotherapy organisations such as Sakoon Islamic Counselling Service, The Lateef Project and Muslim Counsellors and Psychotherapist Network (MCAPN), were also approached by contacting the administrators. The authors of journals and books relevant to Muslim counselling/therapy/psychology were also contacted via emails.

3.2.2 Inclusion Criteria

It was initially intended to recruit Counselling Psychologists only to make the investigation more relevant to the Counselling Psychology field. The researcher however had anticipated difficulty in recruiting participants (after discussing it with the research supervisors, which proved correct during the recruitment process), and the inclusion criteria had to be broadened to incorporate Muslim psychotherapists and counsellers. Six participants agreed to take part in the study meeting the following inclusion criteria: all Muslim therapists who have been trained in at least one (or more) of the mainstream psychotherapeutic approaches such as Psychodynamic, Cognitive Behavioural Therapy (CBT), Humanistic/Person Centred Therapy, or Existential Therapy but also had knowledge of Muslim therapeutic interventions such as Islamic religious healing beliefs and practices, and used such interventions with their Muslim clients.

3.2.3 Participant Details

All the participants were Muslim therapists and used interventions from Muslim perspective with their Muslim clients. Participants belonged to Pakistani-British (n = 3), Bangladeshi-British (n = 1), Indian-British (n = 1) and White-British (n = 1) ethnic backgrounds. Five participants were female and one was a male. Participants were counselling psychologists, clinical psychologists, qualified psychotherapists or counsellors (most participants worked with the NHS, or independently within private practice). The table 1 below provides further information about the research participants.

Table 1: Demographic Details of Participants

Participant (Gender)	Age	Therapeutic Approaches Trained in	Relevant Academic Qualifications	Years of Practice with Muslims	Training in the UK	Muslim Interventions
P1 (F)	57	CBT, Person Centred, Psychodynamic, Existential Therapy	PhD in Psychology, MSc in Counselling & Psychotherapy	20	Yes	Prayers, Reading Qur'an, Names of Allah
P2 (F)	35	CBT, Psychodynamic, Person Centred Therapy	Professional Doctorate in Counselling Psychology	4	Yes	Qur'an, Hadith, Prayers, Dhikr
P3 (F)	45	CBT, Psychodynamic, Systemic Therapy,	PhD in Psychology, MSc in Systemic Therapy	15	Yes	Qur'an, Names of Allah, Qura'nic stories
P4 (F)	54	CBT, Humanistic	Diploma in Counselling and Psychotherapy	25	Yes	Model of self, Qur'an, Sunnah, Sufism, Names of Allah
P5 (F)	42	CBT, Psychodynamic, Person Centred Therapy	MA & a Diploma in Counselling and Psychotherapy	10	Yes	Model of self, Hadith, Names of Allah, Fitrah
P6 (M)	66	CBT, Analytical Psychotherapy (Jungian)	MSc in Clinical Psychology	39	Yes	Model of Self, Fitrah

3.3 PROCEDURE

The study was approved by the Ethics Committee of the University of Wolverhampton, School of Applied Sciences (appendix 1).

3.3.1 Data collection

Interviews are the most widely used method of data collection in qualitative research in psychology (Reid, Flowers & Larkin, 2005), which this study has followed. Smith and Osborn (2003) describe semi-structured interview as the exemplary method for IPA that has been used by the vast majority of work published using IPA (in forty six studies reviewed by Brocki & Wearden, 2006). In line with the inductive emphasis of IPA, the interview questions were open ended and non-directive (Smith, 2004). Although unstructured interviews may justify IPA's inductive epistemology to the fullest extent, a semi-structured interview is mostly recommended for newcomers to IPA (Smith et al, 2009). Semi-structured interviews allowed participants to share their stories openly and reflectively, and develop their ideas and express their concern at some length, thus granting an opportunity to obtain rich data which IPA requires (Smith et al, 2009). At the same time semi-structured interviews enabled the researcher to steer the interview to obtain the data that would answer the research question (Willig, 2008).

Semi-structured interview is a collaborative process, emphasizing that the participants are the primary experts. This approach is certainly in keeping with the aims of IPA research (Brocki & Wearden, 2006). The data obtained from the interview is therefore a product of the interaction between the researcher and the participant. In order to ensure the reflective practice interview schedule was developed with the supervisor's

cooperation, and was also embedded in the previous research on the topic. A reflective journal was also kept and an open and critical stance was adopted throughout.

3.3.2 Interview Schedule Development

The interview schedule was based on recommendations by Smith et al. (2009) for designing research questions. Questions were conducted based on discussions that took place during supervision; were also informed by the researcher's own experience of being a Muslim counselling psychologist in training, and taking part in therapy. The researcher's own experience of seeking religious healing practices outside the therapy provided her with personal insight into some important aspects that might be worth exploring further with therapists who may decide to use Muslim knowledge or practices in the therapeutic process. Questions were also based on the topics raised in previous literature (Haque 2001; Keshavarzi, & Haque, 2013; Rassool, 2015; Skinner, 2010). It seemed important to explore through the personal experiences of Muslim therapists such issues as assessing the usefulness of Muslim interventions for Muslim clients; and their decision making when choosing a Muslim intervention as compared to or in integration with mainstream therapeutic approaches. Questions were also created to explore participants' perceptions about the areas of Muslim therapeutic interventions that had not previously been examined, such as their own subjective experience and their personal journey of becoming a Muslim therapist and using these interventions and any hurdles or ethical dilemmas they might face.

The explorative interview topics consisted of five areas (appendix 2): (i) professional training (aimed at exploring the experience of mainstream training of the participants; (ii) Muslim psychological interventions (exploring the experience of using Muslim

interventions in therapy as well as therapists views on client's experience of these intervention); (iii) usefulness (perceived by therapists and assessed by clients' feedback given back to therapist); (iv) experience of integrating Muslim approaches in therapy (aimed at exploring if there were any challenges); (v) contribution to counselling psychology (concluding questions). The interview was structured to be broad enough to provide an insight into the participant's unique idiographic experiences whilst also gaining answers relevant to intended research questions.

A discussion was also carried out with a colleague who had done a study (Mundra, 2013) in a similar area, which allowed refinement of questions. The interview schedule was reviewed by the director of studies before being submitted to The University of Wolverhampton ethics committee for ethical approval.

3.3.3 Interview Procedures

An information sheet (appendix 4) was sent by the researcher to the participants via email prior to the interview. A consent form (appendix 5) and a demographic information form (appendix 6) were then sent via email or by post once the participant agreed to participate. The following material was considered necessary: consent form, participant's information sheets, debriefing sheet, interview schedule, IPad for voice recording (password protected), MacBook (password protected; for online video conferencing); pen and paper; and a timer on the IPhone.

Most interviews lasted up to an hour. Two face-to-face interviews were conducted in participant's own offices. Three interviews were conducted via online video conferencing and one over the phone. Comparison of the interview transcripts revealed

no significant differences in the interview length or quality of responses. This is consistent with Sturges and Hanrahan's (2004) study which compared the interview transcripts resulting from face-to-face interviews with telephonic interviews and found little difference in the quality of responses. It has been argued that telephonic interviews may lack visual cues resulting in loss of non-verbal data and communication of emotions (Novick, 2008). Telephone and online video interviews however had the advantage of decreasing cost and travel time, increasing the ability to reach geographically dispersed participants, and enhanced interviewer safety (Novick, 2008).

A pilot interview was conducted with one of the participants to examine the suitability of questions to provide relevant information for the research question. No changes had to be made to any of the questions after seeking feedback from the first participant. However, the participant commented on the disruptive impact of too many questions, and it was decided that less prompts would be used in order to facilitate the flow. The data from the pilot interview was included within the analysis, because it was consistent with the remainder of the data, and was relevant and valuable to the research.

Before the interview began, the researcher asked the participant to sign the consent form, informed them of their right of withdrawal from the study (section 3.7.2 for further details) and asked whether they had any questions before the interview commenced. If they had no concerns, the semi-structured interview took place (appendix 2). To begin the interview the researcher asked questions about the participant's mainstream counselling or psychotherapy training, leading gradually into a more specific line of questioning about their experience of using Muslim therapeutic interventions, their perception of its usefulness and any challenges they might face

when using Muslim therapeutic interventions with their Muslim clients. The open-ended questions enabled the participants to elaborate on their answers, whilst also bringing their unique perspective into the interview. Some clarifying questions were also asked to help the researcher to understand the point the participant was trying to make, and on occasions this might have resulted in closed questions being asked. On occasion questions were linked with prompts to help the participant to answer the question if they became a little stuck.

Participants were provided with a debrief sheet (appendix 7) following the interview, and given the opportunity to ask questions and reflect on their experience of the interview. The participants were also informed that they could have a summary of the findings if they wished to, which would be sent to them via email once the study was completed.

3.4 DATA ANALYSIS

Smith et al. (2009) outline a step-by-step guide (used for this study) to conducting IPA analysis. However, Giorgi (2000) argued that a set of prescribed steps for analysis whilst undertaking phenomenological research undermines its true nature and what it is capable of achieving. In defense of the process of analysis offered by Smith et al. (2009) it can be argued that they advocate a systematic process, rather than a prescriptive one (Lyons & Coyle, 2007).

3.4.1 Transcription Process

The audio files pertaining to the interviews were downloaded onto a password protected MacBook and then transcribed into verbatim reports. Non-verbal utterances such as

laughter and pauses were noted using bracketed text as recommended by Smith et al. (2009). Interview transcripts were line numbered. (Written transcripts can be found in the confidential attachment).

3.4.2 Reading and Re-Reading

The analysis started with an immersion in the original data, by reading and re- reading the transcript with a view to getting an overall 'feel' for the interview (Lyons & Coyle, 2007). This process ensures a growing familiarity with the transcript. The audio recording of the each interview was also listened to twice during this process because it helped the researcher to imagine and get a sense of the interview as it was at the time. Following the recommendations of Smith et al. (2009), whilst being aware that researcher's interpretations are vital in the IPA research, the researcher endeavored to bracket off any significant reflections of the interview experience in order to focus primarily on the participants' account leaving the interpretation until the analysis stage. Important reflections were noted in a journal so that her assumptions did not keep the researcher from remaining focused.

3.4.3 Initial Noting

Initial notes were made using Track Changes editing command in word processing as the researcher was reading through the transcript and further exploratory notes and comments were added with subsequent readings (Smith et al, 2009). The researcher endeavored to keep an open mind so as to enable her to identify and understand how a participant talks and makes sense of their experience. The detailed notes involved: firstly, notes made to describe content focussing on the participant's world at face value; secondly, the exploratory notes explored the use of language through tone,

pauses, utterances and laughter; the third level of annotation, which is more interpretative, focused more on the conceptual level of understanding (Smith et al, 2009). This involved using theoretical concepts to make psychological sense of the data (Lyons & Coyle, 2007). However, Lyons and Coyle (2007) have warned that this should not violate IPA's phenomenological commitment, so that participant's subjectivity is not over-written with theoretical conceptualisation, as theories are used to inform rather than drive the analysis.

3.4.4 Individual Case Analysis

This stage of analysis involved the identification of emergent themes to encapsulate the meaning of the participant's account and entwine them with the interpretations and understanding of the investigator. Emergent themes' were noted in red in Track Changes (appendix 8: extract showing the initial notes in black and emergent themes in red); subsequently a list of chorological themes was generated for each participant (appendix 9). Chronological themes were then reviewed and clustered together using colour codes: Each colour signifies a cluster of themes e.g. blue colour (as shown in appendix 10) signifies 'usefulness of mainstream approaches' and these were then checked against the original transcript to ensure that reflections were accurate as suggested by Smith and Osborn (2008). Final themes for each participant were then identified (appendix 11).

3.4.5 Cross Case Analysis

The process outlined above for individual case analysis was then repeated for all the other transcripts, as suggested by Smith et al. (2009). Once the process had been completed the researcher returned to the original transcripts to look for patterns and

potential connections between them, paying attention to differences and similarities and developing a sense of 'superordinate' themes; a theme which ran across most transcripts and discussed more in depth and more frequently was classed as 'superordinate'. Appendix 12 shows grouping of final themes for each participant forming superordinate theme 1: Therapeutic Interventions. Appendix 13 subsequently shows superordinate theme 1: Therapeutic Interventions and its subordinate themes. The figure 1 shows the step-by-step demonstration of how the researcher obtained a superordinate theme.

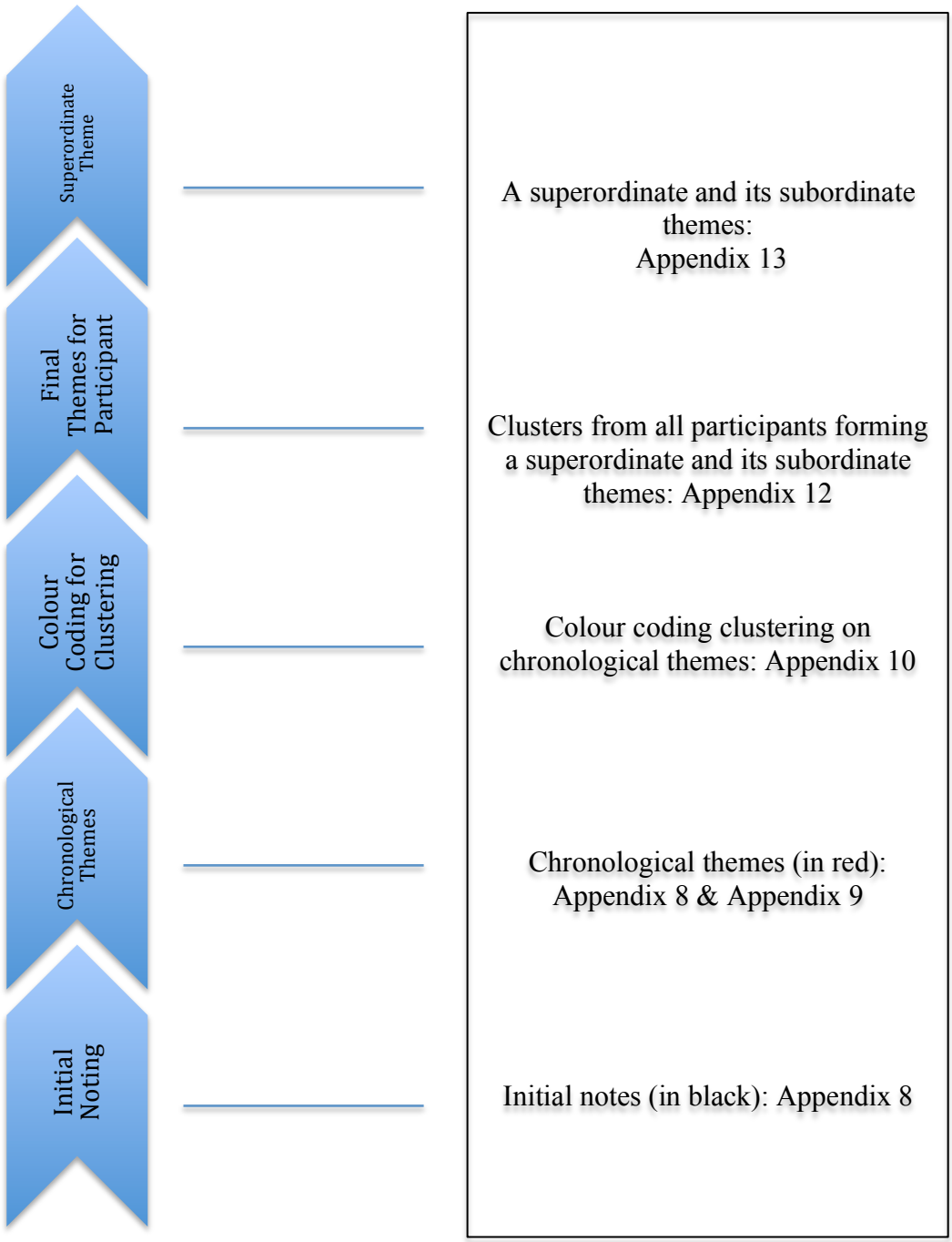

Figure 1: A step by step demonstration of obtaining a superordinate theme and its subordinate themes.

A table of superordinate and subordinate themes (Table 2) was created with relevant sample quotes from the text to make reference to their location within the original transcript.

3.5 RELIABILITY, VALIDITY AND ENSURING TRUSTWORTHINESS

The trustworthiness of qualitative research is often questioned by positivists as it is felt that validity and reliability cannot be examined in the same way as it is in quantitative research where it is associated with empirical concepts such as objective truths and evidence (Golafshani, 2003; Morrow, 2005; Shenton, 2004; Winter, 2000). To ensure the trustworthiness for a qualitative project, Guba (1981) proposed a criteria based on four characteristics of trustworthiness: a) credibility (in preference to internal validity); b) transferability (in preference to external validity/generalisability); c) dependability (in preference to reliability) and d) confirmability (in preference to objectivity). Shenton (2004) further suggested the following provisions should be made to eliminate questions about the accuracy of the research.

Credibility

Internal validity is one of the key criteria addressed by positivist researchers. Lincoln and Guba (1985) argued that credibility in preference of internal validity is one of the most important factors in establishing trustworthiness. The following provisions as suggested by Shenton (2004) were made to ensure this.

'*The adoption of research methods well established'*- certain procedures were employed in this study, for example the questions used in the semi structured interviews were closely linked to the phenomenon under scrutiny and the study has attempted to ensure

credibility by adopting a well establish method of analysis- IPA as a means of looking at phenomenology (Smith, 2010; Smith et al, 2009).

'*Tactics to ensure honesty'*- all the participants were given the opportunity to withdraw from the study up until the data analysis stage. Furthermore, all participants were aware that the confidentiality was ensured and a non-judgmental relational stance was adopted so that the participants could talk about their experiences more openly.

'*Peer scrutiny of the research project'*- the researcher made the most of opportunities to have the research scrutinised by peers and her supervisors (by presenting the research in the conferences, presentations and discussions) in order to gain verbal feedback. Smith et al. (2009) argued that the research process must be transparent to demonstrate validity. Accordingly, the research process was monitored by the research supervisors and questions posed by them enabled the development of a greater understanding of methods employed to conduct research, strengthening the overall design of the project. Furthermore, the findings of the analysis were also reviewed with the research supervisors to verify that a coherent argument was being developed that constituted a valid interpretation of the data.

'*The researchers reflective commentary'*- a research journal was used throughout, where a record was kept of the reflective understanding of the researcher's engagement with client's accounts and research process (reflections from the journal have been presented in the chapter - Critical Appraisal).

'*Background, qualifications and experiences of the researcher'*- the credibility of the researcher and the research team was observed by the ethical committee of The University of Wolverhampton. The research work was continually monitored by the supervisors during the process.

'*Member checks'*- within phenomenology research, the issue of participant validation seems complicated. Van Manen (2016) argued that a dialogue should be established with participants regarding the interpretation of the researcher's account, in order to establish validity of the findings in a phenomenological research. However, the pursuit of participants' feedback on analysis is considered problematic (Langdrige, 2007) and is not widely used or considered necessary in the IPA approach. Langdridge (2007) argued that due to the nature of analysis in phenomenological research, there is a possibility that participants may not recognise the interpretation as being reflective of their lived experience. However, this is not necessarily indicative of error on the part of the researcher.

It may equally reflect that interpretative analysis seeks to disclose a level of meaning apart from that which is explicitly present in participant's original accounts. Due to these theoretical grounds, as well as the limited time constraint for the project, participants' feedback was not sought for the analysis. All participants were however engaged in informal conversations at the end of interviews and participants were given the opportunity to ask questions about the interview process.

'Examination of previous findings'- the results were compared with previous research findings to ensure that the findings are consistent with the existing body of research in the area.

Transferability

The external validity is concerned with the applicability of findings of one study to other situations (Giorgi, 2002). Erlandson (1993) challenged the positivist view of external validity by pointing out that, in practice, even conventional generalisability is never possible as all the observations are defined by the context in which they occur. Stake (1994) and Denscombe (1998) however, presented a contrasting view by suggesting that each case may be unique but is an example within a broader group, the prospect of transferability should not be rejected. The following provisions were applied to ensure the transferability.

'Description of the phenomenon'- Shenton (2004) recommended that the sufficient description of the phenomenon under investigation should be provided to allow the reader to make such a transfer, which this study endeavoured to do throughout.

'Background to the study'- as suggested by Shenton (2004) the background to the study was explored to position the research in a wider context. The relevant studies have been discussed in the literature review section, in order that comparisons might be made.

'Boundaries of the study'- concise information about participants' characteristics, background and a detailed description of their experiential account was given to enable

the reader to make judgments about the transferability of the findings to their context of interest.

Dependability

The positivist researchers' premise that if the research was repeated in the same context with the same methods and participants, similar results should be obtained, was challenged by the researchers (Fidel, 1993; Marshall & Rossman, 2014) who argued that the changing nature of the phenomena scrutinized by qualitative researchers makes this nearly impossible.

Confirmability

The concept of confirmability is comparable to the concept of objectivity for the qualitative researcher. Shenton (2004) argued that the procedures to be followed would ensure that findings obtained were a true reflection of the experiences of the participants, rather than indicating the preferences of the researcher. Choosing IPA over other methodologies was discussed and the limitations of the project were also outlined. Keeping a reflective diary enabled the researcher to return to decisions made at the time. Furthermore, an audit trail (included in the appendices) allows for research to be traced step by step.

3.6 REFLEXIVITY

A reflexive approach urges researchers conducting qualitative research to talk about themselves, "their presuppositions, choices, experiences, and actions during the research process" (Mruck & Breuer, 2003; p 3). Reflective practice aims to make the constructed nature of research outcomes visible to the reader, a construction that "originates in the

various choices and decisions researchers undertake during the process of researching" (Mruck & Breuer; p 3). Rather than attempting to control researcher's values through method of bracketing assumptions, the aim is to consciously acknowledge those values (Ortlipp, 2008).

IPA as a hermeneutic method, is explicitly involved within an interpretative framework which posits that the meanings an individual ascribes to events are of central concern but are only accessible through an interpretative process (Biggerstaff & Thompson, 2008). Interpretation is viewed as a process of discovery in which the researcher must continue to pose questions regarding the data and his/her understanding of it. An explication of researcher's own preconceptions and critical reflections upon her own standpoint prior to the analysis was therefore considered as necessary to be monitored (Biggerstaff & Thompson, 2008). As argued by Willig (2001), reflexivity aims at maintaining a critical and reflective stance throughout the research process, and is at the very heart of the qualitative research.

All the interviews were conducted by the researcher who is a Muslim herself. During her training in counselling psychology, the researcher had started to develop a strong sense that therapeutic interventions based on Muslim perspectives could be very useful for Muslim clients in therapy and reading in the area led to a belief that such interventions had something very valuable to offer to Muslim clients and a unique experience for Muslim therapists. However, insight needed to be gained into how Muslim therapists who had a mainstream training primarily experience the use of Muslim therapeutic interventions with their Muslim clients. This led to conceptualization of the need for this research as no evidence-based research was found to provide such an answer. However, research was started with an open mind about

what the participants might say on the matter. A self-reflective journal was a strategy that was adopted to facilitate reflexivity (Ortlipp, 2008), to examine "personal assumptions and goals" and clarify "individual belief systems and subjectivities" (Russell & Kelly, 2002; p 2). The personal account of the researcher's preconceptions and understandings pertaining to the phenomena of inquiry will be discussed further in the chapter-Critical Appraisal.

3.7 ETHICAL ISSUES

3.7.1 Informed Consent

The initial invitation sheet was sent to the organization referring interested participants to the researcher. Potential participants were also contacted directly via email. The participants gave written consent on a pre-designed consent sheet (appendix 5) prior to face to face interviews, and electronic written consent for the interviews conducted via online video conferencing, and also for telephonic interviews. The consent form outlined the information that participation was voluntary and participants could withdraw from the study prior to the interview and even during the interview, up until the point that analysis began as after this it will be difficult to extract data. Confidentiality would be observed throughout. Participants were also informed that the information might be used if the research was published at a later date, but for academic use only.

3.7.2 Confidentiality

When participants were issued with the consent form (appendix 5) it was important to make them aware that all the information obtained would be treated with sensitivity and discretion. A participant number was allocated in order to protect the identity of the

participant throughout the report. The interview would be conducted confidentially; anonymity of research participants would be preserved throughout, any identifiable information would be omitted. The audio recording would only be used for the purposes of this study. Furthermore all information collected was to be stored in line with the British Psychological Society (2009) codes of ethics and conduct for the protection and safety of the general public, British Psychological Society (2002) guideline on confidentiality and record keeping and Health and Care Professions Council (2016) guidance on conduct and ethics for students. As this project would be accessible on a university website for other researchers and students, consent forms and demographic information would be submitted as a confidential attachment separately. The information will be archived at the University of Wolverhampton for a period of five years or as required.

3.7.3 Safeguarding

The ethical principle of causing no psychological harm to research participants in accordance with the British Psychological Society (2010a), British Association for Counselling and Psychotherapy (2016) and Health and Care Professions Council (2015) guidelines was followed. This was however proportionately implemented so that it did not constrain the detail and depth achieved during the interviews. The topics that conflicted (e.g. sect system: Sunni, Shia etc) were explored with an expression of curiosity instead of presenting it in a challenging manner. The researcher also did not disclose her person views on any particular sect at any time during, before or after the interviews, so that participants would express their views and concerns with more ease and openness. This is in line with Ulrich's (2006) view that the practice of research by posing only questions that were safe would restrict the discovery of new knowledge.

Debrief and check out procedures (Iphofen, 2011) were also carried out to find out how participants were feeling at the end of the interviews, and no sign of distress was reported by any of the research participants. The safety of the researcher was also ensured when conducting interviews at different venues by informing family of her whereabouts and by asking them to contact her if she had not checked in with them by a specified time.

4. RESULTS

4.1 INTRODUCTION

In this section findings from the analysis of six semi-structured interviews using Interpretative Phenomenological Analysis (IPA) are presented. These interviews were conducted with Muslim therapists who used interventions from a Muslim perspective in conjunction with mainstream therapy with their Muslim clients. Table 2 below demonstrates the superordinate and subordinate themes, and quotes examples from the participants. The superordinate themes appear in bold text in capital letters whereas the subordinate themes appear in bold small text.

Relevant extracted quotes from the original transcripts will be cited throughout the analysis in the form of a separate text with indent, or as a part of the running paragraphs, to help the flow (Griffin, 2015). The extracted quotes include the participant, page and line numbers. Utterances such as ‘emm’ and ‘err’ have been removed. Dotted lines will indicate that there was material before and after the extract taken from the bulk of text demonstrated through the use of squared brackets. The three superordinate themes identified are:

- **Psychotherapeutic approaches and interventions**
- **The journey of becoming a Muslim therapist**
- **Obstacles faced by Muslim clients and therapists**

Table 2: Table of Superordinate and Subordinate Themes

Superordinate themes	Subordinate themes	Example Quotes from participants
PSCHOTHERAPUTIC APPROACHES AND INTERVENTIONS	**Mainstream psychotherapeutic approaches**	*"the techniques […] like transference or defenses or thought records these I feel they do have value […] and do work" Participant 2 (Page 34, 829-831)*
	Muslim therapeutic approaches	*"I could apply […] deeper meanings of things and the psychological relevance of […] a belief themselves such as forgiveness or [...] I have been punished [...], try to use Qur'anic stories in therapy"- Participant 3 (Page 4, 89-104)*
	Similar but distinct	"*the concept of self and personality is quite different (from) the way it has been described by the Muslim philosophy as compared to Western philosophy*"- Participant 6 (Page 4, 83-85)
THE JOURNEY OF BECOMING A MUSLIM THERAPIST	**What was missing - a self-discovery**	*"CBT for example or even psychodynamic psychotherapy but their roots are very much non-religious"- Participant 2 (Page 14, 343-345)*
	Knowing the path-helping the clients	*"if the therapist understands something of the train the client is going through so I think for me, for me to be able to work with clients on their religious beliefs, I have to have*

		made (a) journey into that area myself"- Participant 3 (Page 8, 178-181)
	Development and growth	*"We ourselves had a spiritual development and we found that its really important for our healing"- Participant 4 (Page 2, 40-41)*
OBSTACLES FACED BY MUSLIM CLIENTS AND THERAPISTS	**Barriers to therapy**	*"the stigma is similar to you know the Western sort of barriers"- Participant 5 (Page 14, 330-331)*
	Challenges for therapists	*"They would be pulled up on being too religious"- Participant 2 (Page 3, 75)*
	Suggestions for therapy	*"or ethical but if that's what they want then its fine unless they come wanting it"- Participant 1 (Page 13, 303-304).*

Exploration of these superordinate and subordinate themes (table 2) will form the basis of this chapter.

4.2 PSYCHOTHERAPEUTIC APPROACHES AND INTERVENTIONS

The first superordinate theme 'therapeutic approaches and interventions' outlines participants' description of their experiences whilst using different types of psychotherapeutic models and approaches. This sheds light on some of the models and interventions that participants were trained in and/or have knowledge of. These theoretical approaches formed the basis of participants' practice and influenced to a large extent the development of their therapeutic/counselling skills. With time most

participants began to recognise some limitations to these approaches when used solely with Muslim clients. This led to exploration of other therapeutic techniques which participants explored and added to their therapeutic practice. This theme is explored in relation to three subordinate themes which are:

- Mainstream therapeutic approaches
- Muslim therapeutic interventions
- Similar but distinct

4.2.1 Mainstream Psychotherapeutic Approaches

All participants were trained in UK based institutions, this determined which therapeutic models and approaches were part of their training. These included cognitive behavior therapy (CBT), psychodynamic and person-centered approach. Some participants were also trained to use, or had knowledge of, Jungian analysis, systemic therapy and existential approach as shown in table 1.

All participants drew from mainstream approaches and found them useful in their therapeutic practice. Participants perceived mainstream approaches as being advanced, valuable and beneficial for their clients. A quote that illustrates this point comes from participant 4, who commented, “the Western scholarship is, you know hugely advanced”-Participant 4 (Page13, 396-297). She found mainstream models such as CBT very useful in her therapeutic practice, “CBT and stuff; but I think all of these have a value” (Page 35, 857-858).

Participant 2 further highlighted the aspect of mainstream approaches that she particularly found useful in her practices,

> "the techniques […] like transference or defenses (psychodynamic) or thought records (CBT) these I feel they do have value […] and do work" (Page 35, 830-832)

She considered these approaches as indispensable to her therapeutic work,

> "you can do with the psychologist that doesn't involve religion, still beneficial, it's still helpful, so I would not dismiss it" (Page 38, 936-937)

All participants who were trained in a variety of mainstream therapeutic approaches in the UK consider these approaches as an integral and valuable part of the therapeutic process. Participants are also aware that approaches should be adopted according to clients' needs as a specific approach may not be appropriate for use with a client, another may not be appropriate for use in a particular setting, and different approaches might be tailored to suit specific clients as participant 1 stated, "I don't think that one model fits everybody and I don't think that any one model fits for anybody all the time" (Page 2, 39-41).

Although mainstream theories and approaches have much to offer, participants recognised that there were limitations. Each theoretical approach has a different emphasis or point of focus. For instance, the psychodynamic approach explores a client's past experiences and their influence on the clients' present way of being as participant 1 commented, "psychodynamic would say all of our childhood impresses us

hugely and significantly and we spent the rest of our life dealing with it" (Page 3, 62-64).

Similarly cognitive behaviour therapy drawing on the medical model of recovery may look at a client's presenting problems in the form of disorders and symptoms, tending to reduce human function to thoughts and behaviours, and therefore providing a partial understanding of the human being as participant 6 highlighted, "They are very partial, so CBT, for instance, it is very surface theoretically, cognitions hold an influence on emotions and other things and behaviour" (Page 4, 89-92).

Mainstream psychological theories can be quite specific therefore, and because of their distinguishing characteristics can also be quite restrictive as participant 1 added, "CBT does not have a defined model of human being it rests on the idea that everybody has thoughts, feelings and has behaviours but what is a human being isn't answered by their model" (Page 2-3, 48-51).

Participants were aware of and acknowledged that mainstream approaches were not devoid of limitations. They recognised that not all theories allowed for the importance of religious, spiritual or cultural factors which may have a significant impact on the way mental health difficulties and healing is perceived by Muslims. Participants found that the spiritual dimension was missing in the most therapeutic models, "we felt that the counselling that was on offer generally within mainstream sort of circle I know this is not inclusive but it didn't have that spiritual component"- Participant 4 (Page 2, 42-44), or the models were unable to capture the Islamic understanding of spirituality "and

certainly didn't have Islamic understandings of spirituality within it"-Participant 4 (Page 2, 46-47).

They were also aware that Islamic understanding of spirituality and religion is distinct from the Western notion of church dogma, "it is the spiritual one, it may not particularly be religious like catholic for instance"- Participant 6 (Page, 21, 500-501). Participants further highlighted that for Muslims spirituality impacts the way self, mental health and healing is perceived as participant 3 highlighted the importance of spirituality for Muslim clients,

> "for most Muslims like people from most non-Western cultures religion and spirituality and the idea of the spirit as part of the self it is an inherent part of the experience of themselves so if you don't address that you are leaving out a whole dimension which can be very important"- Participant 3 (Page 7, 153-158)

Participant 3 also perceived that mainstream approaches were rooted in the Western culture that has limitations for Muslims clients. Although the basis of their practice might be the mainstream therapeutic approach, where these approaches were not deemed relevant to Muslim clients' context or seem insufficient (further comparison between mainstream approaches and Muslim therapeutic will be made in the next subordinate themes: Muslim Therapeutic Interventions and Similar but Distinct), participants referred to interventions from Muslim perspectives.

Because Muslim psychotherapeutic techniques and interventions are not specifically taught in major training programmes in the UK participants either sought further

training in these models later on during their career or used their Islamic knowledge. Participant 2 stated that she mostly relied on her Islamic knowledge, "yeah just my knowledge"- (Page 18, 440). Others sought help from Islamic scholars, "I was kind of seeking knowledge from scholars"-Participant 3 (Page 2, 44). The next subordinate theme will further discuss how participants incorporated their knowledge of Muslim therapeutic interventions in to therapy.

4.2.2 Muslim Therapeutic Interventions

This subordinate theme sheds light on therapeutic interventions from Muslim perspectives that participants have been using in their therapeutic practice with Muslim clients. Participants' perception of these interventions and how they introduce them into therapeutic practice will be discussed following the detailed description of Muslim interventions and how they were administered by participants in therapy.

Participants perceived therapeutic interventions from Muslim perspectives as being religious, spiritual and cultural in nature. All participants emphasised that the Muslim therapeutic interventions, approaches and models are highly influenced by Islamic teachings derived from "Qur'an and Sunnah (deeds of Prophet Muhammed PBUH)"-Participant 5 (Page 20, 491). The interventions based on these sources included use of prayer in therapy and religious and spiritual beliefs which will be discussed in detail in section 4.2.2.1 and 4.2.2.2.

Participants also utilised Muslim philosophy (Sufism/*Tasawwuf),* "The *Tasawwuf* has done a lot in terms of understanding of the self and healing, so a lot of what Islam has to offer around healing has come from that, that school if you like"-Participant 4 (Page 27,

645-647). Their perceptions and understanding of self and its relation to healing has largely been informed by this philosophy. An ancient Sufi philosopher whose theory of self was mentioned by most participants was al-Ghazali, *"*I rely on the model of al-Ghazali and his model of the self is relying*"*-Participant 6 (Page 8, 186-190). The Islamic notion of self will be discussed in section 4.2.3.1 in detail.

All participants worked holistically with their clients and the context was taken in to consideration. This might include physical, religion, culture and their worldview as a whole, "Whatever the issue is do you want to look at it from your worldview not just your religion but our culture and everything" - Participant 1 (Page 14-15, 345- 347).

Initially participants conducted an assessment to find out what the problem is, how it is affecting the client, and what their goals are which may include spiritual goals such as to explore their relationship with God or making sense of their existential concerns, and finally how they want to achieve these goals,

> "Psychological assessment but in a less formal way and find out why they are angry with God and what's going on for them and then look at what the goals are, how do they want me to help them, do they want to repair their relationship with God or not"- Participant 2 (Page 11, 261-265)

Participant 6 who is a clinical psychologist considered assessment and formulation as being vital to his therapeutic work as this is a stage that will define the route of the therapy and will guide the interventions that will be followed,

> "I am less concerned about the interventions so much as theory. I am a psychologist primarily so I am concerned how do you understand the self

> and if you get that right then you are not going to make wrong diagnosis. If you can't make a proper diagnosis, therapy too is going to be quite wrong"- Participant 6 (Page 3, 69-73)

Most participants reported that they would make a shared decision with their clients about using Muslim interventions at the time of the assessment as participant 1 stated, "You wanna do straight CBT which you know this is what CBT is, if you wanna use (a) different approach, is this approach then we make a shared decision at that point"- Participant 1 (Page 15, 348-351). The holistic and open stance of the therapist may provide a space for clients to be more comfortable and less restricted in setting appropriate goals and tasks in therapy, and may be a first step to initiating a therapeutic alliance in which clients' complex needs can be expressed. Muslim therapeutic intervention that were utilised by participants in their therapeutic practice with Muslim clients are discussed below.

4.2.2.1 Prayers Used as a Therapeutic Strategy

The prayers that most participants utilized included issues around daily obligatory prayers, recitation of the holy Qur'an, and Dhikr/Ziker (remembrance of God) using names of Allah and Du'a (supplication) for healing in their therapeutic work. Participant 3, for instance discussed that she has used names of Allah and explored meanings of each names which may have a healing capacity for Muslim clients, "for that person what the unique meaning and unique experience of that name (of Allah) is"-Participant 3 (Page12, 288-289).

Participant 1 further stated that she had performed a Du'a or recited a little verse from Qur'an with clients in therapy according to client's needs and goals, "I've with some clients done a Du'a (supplication) or a little Surah (verse) of Qur'an if that's what they want to do"- Participant 1 (Page 26, 620-622). Participant 2 also suggested these forms of prayers to her Muslim clients to seek Allah's protection in times of distress, "You can do your Izkaar (Zikr), you can do your Salah (prayer) you can read Qur'an, you can make sure you ask Allah to protect you" - (Page 14, 328-330).

These practices could be performed at home or within the therapy such as daily prayers would mainly be performed at home, however, clients might want to discuss issues around them in therapy, "I tend to share with them, get them to go away and do themselves because I think it's about going inward"- Participant 1 (Page 26, 627-629).

Participants tended to feel more comfortable performing a short prayer within the sessions in the form of supplication, or recitation of a short verse from Qur'an at the beginning or during the session according to a client's needs. However, participants were hesitant to use long verses of the Qur'an during a session, as these were time consuming and the session was needed to explore complex psychological processes, "but I do wonder why they want to do it in session unless there is a good rationale for it"- Participant 1 (Page 26, 632-633). Participant 2 further highlighted the risk that this might be used as a defense by some clients to avoid exploring painful emotional and psychological processes "you can run the risk of masking deeper psychological issues so I'm really careful about that" (Page 4, 81-83), she added if it happens that client is using it as defense, therapists should be open and congruent about it and reflect it back to client.

Participants had concluded that when using prayer therapeutically it is important to understand it, being mindful and having the heart present makes the religious practices such as daily prayers more meaningful and helpful in mental distress. Participant 1 shared her story when she was asked to read Surah Rehman (verses from the Qur'an) for anger related issues. She was helped to develop an understanding that this Surah was about gratitude and kindness, and might help her to forgive the person she was angry with and move on. Understanding made the verse more meaningful and facilitated her openness and readiness to recite the Surah, allowed the process of healing, and made it more effective,

> "It was about me opening my heart before I tried to because you can't if you don't open, you can't allow the healing (to) begin as effectively" - Participant 1 (Page 29, 701-703)

Thus participants felt that religious practices can be used therapeutically. However it is the exploration of these practices that makes it more meaningful. Along with religious practices participants incorporated religious and spiritual beliefs into therapeutic practice to facilitate healing and growth for Muslim clients.

4.2.2.2 Religious Beliefs

All participants felt that Muslim clients might have religious, spiritual or cultural beliefs about their mental health difficulties and healing and attending to these beliefs can facilitate therapeutic change. Some of these beliefs, and their therapeutic significance as perceived by the participants, are discussed below.

Punishment Versus Test and Trials

Muslim clients often viewed their mental health difficulties as a punishment from God, or a test. Participants felt that most of their Muslim clients usually had a counterproductive belief that suffering was a punishment from God for their sins, "someone will say things like it's a punishment"- Participant 1(Page 15, 369). This beliefs can be challenged by the therapist, using counselling skills, as participant 1 has been practicing with her Muslim clients, "why you think it's a punishment because Allah gives Jizzah (the reward of our actions) at the end of our lives, just to explore that, where that has come from" (Page 16, 372-374). By exploring clients beliefs in therapy may promote alternative understanding and give them new frames of references, "it can't be punishment so you know, then penny drops, and their cognition changes slightly"- Participant 5 (Page 20, 475-476). Participant 1 further states, "this is about opening the mind to alternative hypotheses" (Page 16, 379-380).

Through this process of change in the belief system, participants tried to help their Muslim clients find hope and meaning in their suffering, as participant 1 stated that she would suggest to her clients, "it says in Islam if you have pain then you get your sins forgiven or it has meanings in some ways" (Page 15, 363- 365) and client's response might be like "wow you know I really like the idea that it forgives my sins" Participant 1 (Page 16, 390-391). She also felt this process might give the distress meanings and not only facilitate healing but also provide further openness and readiness to try other forms of behavioral and practical strategies, "then more concrete strategies like reading the Tasbeeh (Zikr) or reading the Namaz (prayer) or reading the Qur'an become a better focal point"-Participant 1(Page 16-17, 393-395).

Other religious or spiritual beliefs that participants found helpful are discussed below.

A Belief in Destiny and Life after Death

The belief in destiny (*Qadar*) indicating that pain experienced by clients happens for a reason and has meaning, and will be rewarded by Allah in this life or hereafter can be used therapeutically according to Participant 2 (Page 29, 713-718). Participant 1 found that the belief in afterlife could be very helpful if used in therapy for Muslim clients who were grieving, "like grief and belief in afterlife helps people to let go of the person they have lost because they know they still exist somewhere"- Participant 1 (Page 31, 749-751). The belief in destiny and life hereafter was also used by Participant 5 for bereavement therapy with a client who had lost her child, "we have this opportunity to join them in Jannah (Heaven)"- Participant 5 (Page 9, 224-225) in order to facilitate healing.

Acceptance of a Supernatural 'cause' regarding Mental Health

> "with Muslim patients we tend to get a lot of referrals around Jinn, black magic, evil eye" - Participant 2 (Page 9, 218-219).
>
> "people, you know sort of mix up mental health, Sehar (spell) Jinn possession"- Participant 5 (Page 21, 503-504).
>
> "a Muslim might have an inspiration or belief that the disturbance is due to black magic" Participant 6 (Page 14, 324-326).
>
> "the Ableese (devil) and the interpretations of how that's impacting their mental health" Participant 2 (Page 9, 221-222).

The above extracts highlight that a belief in supernatural phenomena such as jinn possession, evil eye, sehar (spells) or black magic and whisperings of devil (doubts), for an explanation of mental health difficulties was commonplace amongst Muslim clients in therapy. It is vital for therapists to understand and validate these complex beliefs. Once these beliefs are heard and validated by the therapist, this can put clients at ease, "that immediately gets their defenses down"- Participant 2 (Page 12, 277-278). After this, more psychological processes can be explored and strategies can be offered, as participant 2 shared a story where a clients' friend had started seeing the client's boyfriend. The client believed the friend had put the evil eye on her. Participant 2 stated that being a Muslim therapist helped her to understand and validate client's beliefs about the evil eye, and offered her strategies such as 'Zikr' to seek protection of Allah from the effects of the evil eye. Also as a psychologist she invited her client to reflect on underlying psychological aspects of rejection and betrayal and their roots in her childhood,

> "we looked at psychologically her vulnerabilities and you know, yes it could be evil eye however you been through so many experiences in your life where rejection and betrayal are gonna be really painful things for you to experience"- Participant 2 (Page 13, 317-320)

This holistic stance helped therapist to validate client's health beliefs as well as work with the psychological aspect. Being a Muslim participant 2 believed that supernatural phenomena such as black magic and spirit possession do exist and as a counselling psychologist she looked at clients' emotional and psychological vulnerability, which may have made clients more prone to be impacted by these phenomena,

> "the more emotionally and psychologically vulnerable you are, the worse affected you will be or the more affected you will be, if somebody does something to you" (such as evil eye or black magic)- Participant 2 (Page 12, 291-294)

Similarly participant 5 highlighted the psychological aspect of taking responsibility for their recovery so that the clients do not use supernatural causes as a defence.

> "so what happened to the responsibility then, you know where does his responsibility come in to it, he is saying that you know it's all down to the black magic"- Participant 5 (Page 23, 553-555).

Thus it can be seen that participants had incorporated religious and spiritual beliefs (e.g. destiny, life after death) and practices (e.g. prayer and supplication) into therapeutic practice with Muslim clients. However, they worked holistically, bringing it to clients' attention that spiritual aspects are often intertwined with psychological aspects. Healing at both levels: psychological and spiritual is therefore required in order to facilitate mental health.

The role of such beliefs in relation to the therapeutic alliance will be discussed in section 4.2.3.4.

4.2.2.3 Why Muslim Therapeutic Interventions

It can be seen that participants had been using a variety of Muslim beliefs and practices in their practice. This is despite the limited knowledge and training they had in these approaches and techniques. Muslim therapeutic approaches were perceived as a fresh

perspective into traditional therapeutic approaches as they were underpinned by diverse philosophies based on cultural and religious traditions, "it's a different flavour to Western psychology in that sense and it comes from different philosophical roots"- Participant 3 (Page16, 389-390).

The primary reason participants used Muslim interventions and approaches was that they felt that mainstream approaches were sometimes insufficient to address their Muslim clients' spiritual and cultural needs as discussed earlier. Participant also felt that there was a need within Muslim community living in the UK as participant 4 reflected,

> "there are a lot of Muslims who did not feel comfortable in fact the opposite that going to practitioners within the mainstream, so there were a lot of people, there was a need within the community"- Participant 4 (Page 3, 51- 54)

Participant 5 also highlights that it was Muslim clients' preference to see a Muslim therapist who would have some understanding of their context,

> "every single one of my referrals you know that's what they want, they do want someone who is Muslim […] empathy as well you know and understanding as well is there, if you know what it's like to be a Muslim,"- Participant 5 (page 7, 171-191)

Participants further found that the use of Muslim interventions in practice was very useful. Below they share some of their reflections on the outcomes of using Muslim interventions in therapy,

> "incorporating religion into therapy and seeing the huge improvement that they have made not only psychologically but with their relationship with Allah, has just been indescribable really" - Participant 2 (Page 15, 363-366)

Participant 2 highlighted that for Muslims personal growth may not only have meant elimination of psychological symptoms, but also growth at a personal as well as spiritual level as that might have been their goal of therapy. She also expressed a sense of satisfaction with her work when using these interventions. Participants 5 further claimed to have a good client base and felt that her clients valued her work and stayed in therapy, "people do keep coming back and they are referring other people to me, so I'm assuming it's working"- Participant 5 (page 4, 97-98). Participant 4 found Muslim interventions to be more cost effective and were shown to have better outcomes on depression and anxiety assessment scales that she carried out with her Muslim clients, such as The Patient Health Questionnaire (PHQ-9) and Generalised Anxiety Disorder Assessment (GAD-7),

> "it is shown to be more cost effective and the, you know we use the PHQ-9 (Depression scale) and GAD-7 (Anxiety scale) and (its) shown to have an impact"- Participant 4 (Page 22, 528-531)

Usefulness and relevance are not the only reasons participants have used Muslim interventions in their practice. Muslim therapeutic interventions were similar in some ways to mainstream approaches in their structure and application. Some of the parallels that ran across both approaches are as discussed in the next subordinate theme. Points of departure will also be discussed.

4.2.3 Similar but Distinct

Participants touched upon the common ground and aspects between mainstream therapeutic approaches and models that are similar to Muslim therapeutic approaches and models. In both Muslim interventions and the mainstream approaches it was believed that theories and models should not be imposed on clients (P3, lines 488-490). Therapists worked at the clients' pace, and tried to respect their decisions and choices when trying a psychotherapeutic technique or intervention. Most participants introduced Muslim interventions as well as other approaches at the time of assessment and according to the needs of their clients. The decision to use certain approaches was a collaborative one, informed choices facilitated therapy as a co-creational process.

Despite similarities and parallels with mainstream therapeutic approaches, Muslim therapeutic interventions have some distinctive features which are significantly relevant when working with Muslims clients in therapy as they are grounded in two different philosophical traditions, as participant 6 asserted,

> "both have different traditions in them but if you took those philosophical traditions according to psychology, then yes with the exception of Jung, it can be quite different, some are very different"- Participant 6 (Page 4, 86-89)

He however acknowledged that there were similarities between Jungian psychology and Islam in that both acknowledged spiritual dimensions. Participant 6 added that the Islamic concept of true dreams was also comparable with Jungian philosophy, which is very distinctive from Freud's dream analysis,

> "the Muslim concept that there is (are) true dream(s) which are particularly important that is the more or less distinction that Jung made that you would not find this with Freud for instance and CBT would have nothing to do with it at all"- Participant 6 (Page 5, 108-112)

Participant 6 explained that dreams have a spiritual entity and that the inner self is opened to inspiration from Allah which can manifest itself in true dreams and the only mainstream model which accepts the spiritual dimension of the dream is Jung as he stated, "The only Western model that has this is Jung […] Freud specifically denied there was any true dream"- Participant 6 (Page 6,136-142). Participant 6 also expressed the concern that Freud's dream analysis specifically denied the existence of true dreams, which is restrictive for Muslim clients if they do have a true dream which then may be misinterpreted or restricted by using Freudian dream analysis which can disappoint the client, "Freudian trained psychotherapist I mean, if I had a true dream, it would be completely misinterpreted"- Participant 6 (Page 6, 128-130). Thus it can be seen that Muslim therapeutic interventions entail therapeutic aspects that are distinct from mainstream therapeutic approaches and might be more relevant to Muslim clients. The next section will discuss some distinctive features of Islamic notion of self.

4.2.3.1 Islamic Notion of Self

All participants appeared to be fascinated by the Islamic notion of self and its distinctive features,

> "the concept of self and personality is quite different (from) the way it has been described by the Muslim philosophy as compared to Western philosophy"- Participant 6 (Page 4, 83-85)

Participants shared their perception of structure of the self and compared it with mainstream models. According to Islamic notion of self, the heart is the centre and intellect (*Aqal*) is mainly guided by the heart, whereas other psychological models such as CBT focuses on cognitions and thinking. In the Muslim model of self,

> "the heart is central, that's the core of the self, then intellect is the secondary to that because the intellect should be guided by the heart"- Participant 6 (Page 9, 196-198)

It was considered that the heart could impact a mental state by affecting cognitions and emotions. Participant 2 described that it is 'heart' where all the emotions, positive or negative lie. In her practice with Muslim clients in therapy, she has been working with clients' negative feelings of the heart such as "anger, jealousy […] showing off, arrogance and pride" (Page 19, 459-460) and their impact on mental health. She also works holistically incorporating religious and psychological interventions to help Muslims clients deal with the impact of these emotions.

Participant 3 further discussed the structure and the development of self, in terms of the lower self that is driven by the lower drives (Nafs al Amara) and higher self (Nafs al Mutmiana) that is more refined. Participant 3 felt that the concept of higher self and human potential to transcend and be at peace as to the certitude of Allah is something that has a wider scope for Muslim clients' development and growth,

> "So its understanding the individual relationships with God and taking yourself beyond the limits of what I guess, would be called in Sufi psychology, the lower self, so from the Islamic perspective the notion of

> self, you know it's kind of quite vast, it's not seeing this 'the personality' in the Western context […] which is self that is more realized"- Participant 3 (Page15, 354-363)

Mental health difficulties were not viewed as pathological but as a potential to grow personally and spiritually because according to the Islamic perceptive a person is seen as a spirit that may have limitations and struggles, but can transcend them,

> "before we see the pathology, you know, if you like we're seeing this person as a spirit, as someone who has that potential to be higher than the angels"- Participant 4 (Page 7, 169-172)

For participant 4 the goal of therapy is to help clients to try to see this highest potential, "in terms of our interventions one of the things that we do is to try and see this highest potential in our clients"- Participant 4 (Page 7, 164-165).

Holistic and Collectivist Notion of Self

In Islamic-Eastern culture the collectivist notion of self is emphasized according to participants. The collectivist notion of self is distinct from Western perspective where self is perceived in individualistic terms as participant 3 highlighted,

> "There is a lot of literature in medical anthropology about non Western cultural constructions of self and through my research, I became very aware that you know, people not just from South Asia but also Middle East and Africa too have much more what is called socio-centric notion of self"- Participant 3 (Page 13, 322-326)

She further highlighted that there is no mind-body split as it is sometimes perceived in the Western psychology in terms of Cartesian split, believing that mind and body are separate entities,

> "there hasn't been a split between mind and body as it has in the Western context, following Descartes. So the notion of self tends to be much more holistic and it involves, mind, body and spirit"- Participant 3 (Page 14, 331-334)

Whereas for Muslims clients 'self' comprises mind, body and spirit,

> "there is not always a sharp demarcation between the physical and the emotional and they may refer to the physical as well as they are also talking about the emotional" Participant 3 (Page 14, 338-339)

Muslim clients therefore expected therapy to be a space where they could explore all these dimensions. This manifested in the practice of participant 2,

> "I deal with everything, everything else is split so you would go to your imam and just tell him one thing about one bit and you go to your psychiatrist and tell him about one load of symptoms about one thing and then you might go to your psychologist and talk about your emotions"- Participant 2 (Page 10, 242-246)

It can be argued that due to its emphasis on spirituality, holistic and collectivist perspective, Islamic notion of self is distinct from the concept of self as perceived in the West. The next distinctive feature is reliance on God.

4.2.3.2 Reliance on God: A Source of Resilience

Using interventions from Muslim perspectives made both Muslim clients and therapist more resilient and committed to the therapeutic process due to their reliance on Allah. Participant 4 made comparison between humanistic approach and Muslim therapeutic perspectives, "if you are committed to humanity, you know humanity lets you down […] right, like your humanistic therapy humanity lets you down but Allah doesn't" (page 6, 141-144).

Reliance on Allah puts Muslim clients and therapists at ease and makes them less anxious about the outcomes of therapy, relieved that they can do their best but ultimately it is the will of Allah, "It's not my decision to make it success […] He will do whatever it needs to happen and its such a relief"- Participant 1 (Page 24, 572-576). Participant 1 found it very liberating as she says, "your best is all that's required. So for me it's very releasing"- Participant 1 (Page 24, 581).

Relying on Allah for client's recovery is another distinct feature of Muslim interventions that can make both Muslim client and therapist more resilient.

4.2.3.3 Shared Language

All the participants tend to use Islamic terminology in their therapeutic practice with Muslim clients. Participants felt that using a shared language provided common ground and facilitated a bond between Muslim client and therapist. Participant 3 felt that language that Muslim clients were more familiar with made therapy more meaningful to them,

> "So being able to speak in their language in a way, being able to refer to things that are meaningful for them, as well as the thing that I actually think that holds collective power was actually quite healing. So it was like speaking someone's language - in a way that makes sense"- Participant 3 (Page 6, 131-135)

She further asserted that shared language had collective healing capacity which connects people to each other and gives them a sense of support and identity, "I mean something that connects people to their communities, to their sense of identity"- (Page 6, 141-142). Hence it can be argued that use of shared language can facilitate a connection between Muslim client and therapist, and can have a therapeutic value for Muslim clients by strengthening their sense of connectedness.

4.2.3.4 Enhanced Therapeutic Alliance

Participants agreed that the therapeutic alliance was one of the major predictors of positive outcomes of therapy and having knowledge of Muslim beliefs and practices enhanced the therapeutic relationship with Muslim clients. As participant 5 stated,

> "in a positive sort of outcome and I think the main portion is the client themselves […] and then it's a therapeutic alliance […] by being Muslim I think that helps the therapeutic alliance but they also want someone who has some knowledge" (Page 11, 255-265)

Participants stated that being Muslim helped in having a shared understanding of clients' belief system, enabling them to show understanding and empathy towards their Muslim clients. Participant 2 felt once clients' complex religious, spiritual or cultural

beliefs were heard, accepted and validated and this made them more open to therapy, "they know that I believe in these things"- (Page 12, 277), so they were more at ease, which helped enhance the working alliance, and often ensured that clients prolonged therapy and experienced better outcomes, "they continue coming" (Page10, 249) as participant 5 stated.

Thus it can be seen that aspects of the Muslim therapeutic perceptive are distinct from mainstream approaches, and this makes them more relevant to Muslim clients' spiritual and cultural needs.

4.2.3.5 Incorporation of Both: Muslim Therapeutic Interventions and Mainstream Approaches

Participants found that Muslim interventions were more meaningful and relevant to Muslim clients' needs; at the same time they found that mainstream approaches were very valuable, scientifically robust and advanced. They therefore had used Muslim interventions with incorporation of mainstream approaches. They acknowledged that both the traditions are equally important since Muslim clients can come with a variety of issues. This may require an in-depth psychological exploration as well as spiritual healing at the same time.

As participant 3 acknowledged,

> "apply other techniques that might be useful…with Muslim clients, issues aren't just to do with religion and spirituality but they are also to do with family and relationships, past experiences, trauma, abuse all of theses kinds

> of issues. So those need working with as much as their religious and spiritual beliefs (Page 9-10, 222-227)

Participant 2 also used both approaches in conjunction to each other and found it more useful for Muslim clients,

> **"**from my perspective, it has to be two prone approach […] you have to be doing both at the same time, I think both, one without the other is, it works but it's less effective than the both at the same time" (Page 14, 330-333)

Thus it can be seen that Mainstream psychological approaches and Muslim therapeutic interventions have distinctive features that are equally important when working Muslim clients. A therapeutic work that incorporates both can offer a more holistic healing for Muslim clients.

It was also evident that participants' knowledge, experience and perspective on healing had a profound impact on their therapeutic practice. The second superordinate theme will therefore cover how participants perceived their own journey of being a Muslim therapist and how that contributed to their therapeutic practice with Muslim clients.

4.3 THE JOURNEY OF BECOMING A MUSLIM THERAPIST

Most therapists started as mainstream therapists; over time they started to become more interested in Muslim therapeutic techniques in their practice. The move towards building on or acquiring further knowledge was an interesting journey in itself, often fuelled by personal and practical experiences. The subordinate themes as below share some of these insights.

- What was missing- a self-discovery
- Knowing the path- helping clients
- Development and growth

4.3.1 What was Missing - a Self-Discovery

This subordinate theme sheds light on participants' experiences, where they experienced a sense that there was something missing from their educational learning experiences, because they began to feel dissatisfaction with their initial mainstream training. Participants being Muslim therapists "felt uncomfortable with the theoretical underpinning" (Participant 6-Page 2-3, 48-49) of mainstream therapeutic approaches, and secular worldview of most psychological approaches in which therapists were initially trained as participant 2 stated,

> "CBT for example or even psychodynamic psychotherapy but their roots are very much non-religious and in fact both of those therapies, their founders were you know religion was something that you need to kind of get rid of in a way"- Participant 2 (Page 14, 343-347)

This seemed to have evoked a sense of frustration, dissatisfaction and ultimately despair. It also posed a challenge for their worldview and devalued their belief system within the 'scientific' tradition of psychology. To meet Muslim clients spiritual and psychological needs and to help their state of despair that had been created by their initial training in mainstream therapeutic models participants began to use their Islamic understanding and knowledge into their therapeutic practice, "using […] just about everything that I have learnt in terms of or understand about being Muslim"- Participant 5 (Page 3, 56-58).

Most participants were born Muslim and learning about Islamic teachings and practices has been part of their upbringing, so thinking about religious/spiritual healing practices while working with Muslim clients felt very natural. However, being born and brought up in a Muslim family did not mean participants accepted Islamic values blindly or without choice. All participants including participant 6 who had converted to Islam, seem to have adopted Islamic values by choice, "So it's a journey, but I was very interested in the idea, do we ever make a choice because Islam is a choice and every time we do a Sajjdda (postulate in pray) it's a choice"- Participant 1 (Page 8, 195-197).

Participants had their journey and struggles with Islam, which helped them to grow at a personal and spiritual level. This also helped them to understand their clients' journey and struggles with religious issues, enhancing their therapeutic work. This will be discussed in the next subordinate theme.

4.3.2 Knowing the Path - The Personal Journey with Religion and Spirituality

Most participants were brought up according to Islamic culture and traditions. Participants were also brought up in the UK and were therefore part of a wider Westernized culture, where their religious and cultural values may have been questioned time and time again. Participants' initial understating of Islam developed through commonly held beliefs or through Islamic teachers who participants felt often had a limited or rigid understanding of Islam or did not know how to make religion meaningful, which made them question their faith. The rigid explanations evoked negative feelings in Participant 1, who experienced resentment towards religious practices, "the philosophical grounds that we were given, doesn't always help because

of the way it's portrayed by the gatekeepers"- Participant 1 (Page 9, 205-206). She further stated,

> "We had an Islamic tutor coming in, I didn't like and I didn't agree with so I could very well then have decided that Islam doesn't make sense, it's not logical"- Participant 1(Page 7,167-169)

Participant 4 experienced similar tensions with how the religion was portrayed,

> "I grew up as a Muslim and I could never understand what it was all about except from miserable things: do this, don't do this, do this, don't do this; and nobody really, I didn't really care about all of that stuff. You know it just seemed (more) like (a) burden than a joy"- Participant 4 (Page 27-28, 667-671)

Participant 4 felt that religious practices imposed without any understanding and meaning became an obligation and a burden. This has psychological implications if one didn't follow the practices guilt, anger and negativity about oneself and religion could develop, as participant 4 shares,

> "The way it's portrayed is, that you know it becomes a problem for people, it becomes a negative thing for people, they feel guilty about it or they feel angry about it"- Participant 4 (Page 5, 112-114)

Furthermore, a person who did not follow religion may be judged and looked down on by their families or their community for not being religious or good enough morally. This may create a vicious circle of negativity and guilt. However, participants' personal questions about religion led them to look for the truth for themselves,

> "instead I read the Qur'an, Alhamdulillah and I said there is nothing there I totally disagree with, on the other hand there is stuff that does not resonate with what other people have been telling me so as far as I was concerned, Islam became my journey about my understanding and hopefully it's made me a little bit more tolerant towards other people who had a different understanding because there is (a) variety of understandings"- Participant 1 (Page 8,179-186)

Participants' despair created a void, they started searching for more knowledge about Islam. Most participants relied on authentic sources of Islamic knowledge, the Qur'an and Hadith, rather than following commonly held religious beliefs and interpretations and tried to develop an understanding which was more meaningful. They described beginning this quest with critical and open minds as participant 4 stated, "I was looking for spirituality and I was looking for answers I didn't confine myself thinking it has to be Islam " (Page 29, 699-700).

Islamic beliefs and concepts started to make sense when participants developed their own understanding and interpretation of it. They found they had agency and choice with religion, it did not feel like dogma, obligation or a burden any more. Participant 1 stated that having had her own struggle with religion, had made her more empathetic towards her clients' struggle with performing religious practices, "people will say, I don't want to read my *namaz* (prayer) and I would say okay it's not my job to judge you" (Page 18, 434-436).

Participants helped clients to understand that if for some reason they could not perform religious practices, Allah would reward them for their intention to do so as intentions are equally important in Islam. Challenging clients' commonly held beliefs and helping them to develop an open attitude might stem their feelings of guilt and isolation and nurture hope and confidence and less of a rigid view of religious practices and beliefs. Participants felt that this ability to show a great level of empathy for clients' struggles with religious practices came from their own personal journey and experiences.

All the participants stated that their personal journey with religion and spirituality helped them to understand Muslim clients' predicaments. Participant 3 believed that having had a similar journey was vital to helping Muslim clients in therapy as this might have enhanced their empathy towards Muslim clients,

> "if the therapist understands something of the train the client is going through so I think for me, for me to be able to work with clients on their religious beliefs, I have to have made (a) journey into that area myself, I have to have explored it and been able to be critical about it, to try and understand something of (what) that process might be like so it doesn't mean I have to have the same beliefs" - Participant 3 (Page 8, 178-184)

Participants personal journey seems to have helped them to understand their Muslim clients struggles and dilemmas. Because of this participants were able to express more empathy towards their Muslim clients, and gradually helped them to alter their unhealthy beliefs facilitating change.

4.3.3 Development and Growth

Participant 4 stated that her own spiritual development made her aware of the healing entity of spirituality. She started using these aspects in her practice with Muslim clients in therapy because she thought that her clients will also benefit, "We ourselves had a spiritual development and we found that it's really important for our healing" - Participant 4 (Page 2, 40-41). Knowing the importance of Muslim therapeutic interventions, participants sought further training and supervision for their personal, professional and spiritual growth. Most participants had furthered their knowledge about Islam by seeking knowledge from Islamic scholars as participant 4 explained: "we spent about ten, twenty years plus on a Sufi path with a teacher" (Page 26-27, 643-644).

However, seeking guidance from Islamic scholars had limitations as they were not qualified clinical supervisors, therefore participants could not discuss their clients' issues. Participant 1 therefore expressed her desire that she wanted a supervisor who had knowledge of both spiritual and psychological domains. She further highlighted that whilst Islamic scholars were a source of knowledge about Islamic healing, and supervisors were a source of psychological knowledge with whom one could discuss clients' issues, it was difficult to find a supervisor trained in both.

> "I need a sheikh I need someone or a Sheikha that I can go to with my clients' issues, with psychological issues who has that deeper understanding and knowledge of Islam"- Participant 2 (Page 21, 509- 513)

Participant 2 also expressed her concerns about lack of training that was available regarding Muslim interventions, "no there isn't any training out there that is the short

answer, I have had a look and I haven't found anything that's met my needs" (Page 20, 489-491). Participants who have decided not to go for training believed that the training available is very basic and overlaps with mainstream counselling training. This suggests that there is a need for further training courses in Muslim therapeutic models and interventions as Muslim therapists preferred using these interventions and wanted to learn but found it challenging to further their knowledge. This leads us to the next superordinate theme, which explores obstacles and challenges faced by Muslim therapists and Muslim clients in therapy.

4.4 OBSTACLES FACED BY MUSLIM THERAPISTS AND CLIENTS

This superordinate theme will highlight the barriers that Muslim clients have, as well as challenges that Muslim therapists face whilst working with Muslim clients in therapy.

The barriers for Muslim clients included stigmas or taboos associated with therapy and fear of being misunderstood by a non-Muslim therapist, and confidentiality issues with a Muslim therapist. Participants also highlighted the ethical concerns of higher expectations of Muslim clients and dual relationship issues, credibility issues for using religious interventions and bias amongst other professionals. Participants also had suggestions with regards to some of these barriers.

This superordinate theme has three subordinate themes:

- Barriers to therapy
- Challenges for therapists and ethical dilemma
- Suggestions for therapy

4.4.1 Barriers to Therapy

Fear of Being Misunderstood by Non-Muslim Therapists

Muslim clients felt reluctant to seek professional help for their mental health difficulties because they fear being misunderstood and devalued for their religious beliefs by a non-Muslim therapist as participant 5 highlighted, "their religion is misunderstood by the non-Muslim therapists" (Page 14, 333-334).

Participants also expressed their concerns that Muslim clients feared that their collectivist cultural values and religious beliefs may not have been understood by a Western trained non-Muslim therapist, having an individualized and secular worldview may offer them a therapy incongruent with their religious, spiritual and cultural beliefs,

> "their emphasis on the collectiveness of the family or the importance of religious beliefs wouldn't be valued and the therapists would only approach them in terms of (a) much more individualised perspective"- Participant 3 (Page 6, 127-130)

Participants stated that either Muslim clients felt apprehension consulting non-Muslim therapists or they didn't feel comfortable expressing their religious or spiritual concerns,

> "what a lot of clients do is that when they go to mainstream counsellors they odd it out things that they just know that counsellor won't understand so they just don't speak about them"- Participant 4 (Page 34, 826-828)

The fear of being misunderstood may have been due to therapists' lack of knowledge of Islamic beliefs or their preconception and misunderstanding of Islam and Muslims. Muslim clients also felt frustrated if they had to explain their beliefs to educate the

therapist, which was time and money consuming, “don’t have to explain why I pray five times a day”- participant 5 (Page 7, 174). Consequently, they might go to imams or clerics about their mental health problems, and often felt misled by them,

> “the gatekeepers and sometimes they actively make lives difficult for these people so for example, women when they give (child) birth they can have postpartum psychosis or depression, we are just told, their faith is not strong enough that's why they are experiencing these things so I felt like a sympathy with people going through this”- Participant 1 (Page 9, 206-211)

If they are lucky and the imam is aware of mental health problems, he might suggest “therapy” (Participant 5-Page 15, 360).

Participants also discussed the factors which might interfere with the therapeutic process when Muslim clients are working with Muslim therapists.

Stigma and Confidentiality Concerns when Working with Muslim Therapists

Muslim clients often needed courage to seek therapy due to the stigma around mental health problems, but consulting a Muslim therapist may increase concerns over confidentiality due to clients and the therapists often being part of the same wider Muslim community. Muslim clients having limited knowledge of the therapists professional obligation to confidentiality assumed that the therapist might be indiscreet about their problems in the Muslim community. Muslim clients feared that if confidentiality was breached they might have difficulties finding jobs and it would affect their career and marriage prospects. These concerns were highlighted by Participant 5 in the excerpts below,

> "it's initially fears around stigma stigmatization, your marriage prospects that sort of, if someone will find out" (Page 14, 344-345)
>
> "In terms of coming to someone who is Muslim it's, one is like confidentiality you know, if you know someone from their community" (Page 14, 334-336)

Participants identified barriers that Muslim clients in therapy may experience in terms of stigma and confidentiality concerns. They also expressed their concerns about incorporating Muslim interventions into therapy, which are discussed below.

4.4.2 Challenges for Therapists and Ethical Dilemmas

Participants experienced certain challenges and ethical dilemmas whilst using religious interventions in their therapeutic practice. These challenges included issues of a 'dual role', the credibility of using Islamic knowledge, lack of acceptance, and fear of losing credibility as a practitioner amongst other professionals.

Higher expectations and 'magic cure': Dual role

Participants highlighted that clients often had very high expectations from therapy when using religious and spiritual interventions; they expected 'miracles' and a 'magic cure' for their 'illness'. This can be due to confusion in the dual role of a Muslim therapist as practitioner and a spiritual healer. Participant 1 highlighted that it can cause confusion about the nature of therapeutic work, and client's participation and responsibility in his recovery,

> "There is this idea that using the Islamic approach will somehow be more efficient, be quicker and produce miraculous results. But therapy is

therapy, it takes a lot of pain, it takes a lot of showing the vulnerability and there aren't, there are miracles but there is no immediate cure" (Page 14, 340-345).

Addressing the credibility issues

The credibility of Western qualified Muslim therapists using Muslim interventions was problematic because their Muslim clients might not perceive them as qualified to use religious interventions. As participant 1 expressed her concerns, "they don't like it calling Islamic counselling" (Page 13, 317). Participants sometimes addressed this issue by referring their clients to the holy book of Qur'an or Hadith,

"you put Qur'an in front of them and show them where it says that these are the different reasons that Allah might test you it's kind of like, oh wow, then I can't argue with that really" Participant 2 (Page 7, 151-154)

Lack of acceptance, fear of losing credibility as a practitioner

Participant 2, when using religious practices with her clients found that this was not accepted amongst counselling psychology professionals. She reflected on her difficulties of incorporating religious intervention into her therapeutic practice in the excerpts below,

"The profession is quite split some people think it's absolutely you know, of course you would talk about somebodies' faith and it's (an) integral part of them and some psychologists would say no way what's that got to do with therapy why on earth we are going there"- Participant 2 (Page 2, 25-30).

> "They would be pulled up on being too religious"- Participant 2 (Page 4, 75).

She felt that her work was not valued or respected by other psychology professionals, and therefore looked at working outside the domain of psychology. Since she has completed her counselling psychology qualification, she has been working in a chaplaincy service where she felt that she could incorporate faith into her therapeutic practice with more freedom,

> "Where I really had the freedom to talk about religion, use religious language, use religious interventions whilst also using my skills as a psychologist and cooperating psychological theory and, and models" - Participant 2 (Page 2, 33-36)

However, this made her question her professional identity whether she was a counselling psychologist, a chaplain or a psychologist who incorporated religion into therapy, creating confusion about her identity, "I have certainly had (an) identity crisis over the last four years"- Participant 2 (Page 2, 42).

Participant 3 also reflected on her difficulty in incorporating faith into therapy. However, she made some suggestions to raise awareness amongst professionals which will be discussed next.

4.4.3 Suggestions for Therapy

Participants identified some of the barriers and obstacles that Muslim clients and therapists might face, they also made some suggestions. Participant 3 felt constrained in

implementing religious interventions in her mainstream counselling practice because using religion in therapy was "seen by (her) colleagues as something as regressive and backwards" (Page 21, 522-523), and as being her own need rather than the clients' need "it's you and most Muslims don't believe that because they think they know on the basis of what they have seen in the media"- Participant 3 (Page 23, 551-553). She further highlighted the role of media in stereotyping Muslims and Islam and its potential impact on therapeutic process.

Participant 3 however believed that there was a need to have open dialogue with colleagues to bridge the gap between psychology and Islam, and in order to provide appropriate mental health services to Muslim clients,

> "but I also felt like it was really important for me to talk about my work with colleagues and to find ways of writing about it and being transparent about it because it was a way of doing justice to my clients"- Participant 3 (Page 21-22, 523-527)

Participants further observed that Muslim clients sometimes feared that while in a mainstream counselling, their religious, spiritual and cultural background might be overlooked,

> "often they're afraid speaking to a therapist or seeing someone because they would only be understood from that cultural perspective and for example their emphasis on the collectiveness of the family or the importance of religious beliefs wouldn't be valued and the therapists would only approach them in terms of (a) much more individualized perspective"- Participant 3 (Page 6, 125-131)

As a result, clients become disappointed and may drop out prematurely. Hence participants urged therapists to pay attention to Muslim clients' religious and cultural contexts for therapy to be more effective. Therefore all the participants were adamant that there was a need for therapists to develop an in-depth knowledge of Muslims belief systems, cultural values and traditional religious and spiritual healing practices as they believed that without having a comprehensive insight into these areas the complex psychological process cannot be tapped into.

Participants also highlighted the necessity of taking each client's individual needs into consideration and constantly adapting therapy accordingly. For instance a client who is extremely distressed might not want to try any behavior strategies such as prayer or Zikr. As participant 2 highlighted, "often with people who are very very very ill that's not the first thing that I go in with"- Participant 2 (Page 31, 750-752). All participants agreed that an open attitude and a space in which clients' individual needs are appropriately assessed and addressed are crucial. Participants felt strongly that it should be client driven if they wanted to work this way and feel ready to explore their religious beliefs or practice, or it may not be meaningful, helpful or "ethical but if that's what they want then its fine"- Participant 1 (Page 13, 303-304).

4.5 SUMMARY OF RESULTS

In brief, the research touched upon several important findings. The participants were Muslim therapists in the UK who utilised Muslim interventions with their Muslim client in therapy. These included religious, spiritual and cultural beliefs (e.g. life after death) and practices (e.g. prayer) in therapy and Muslim philosophy (e.g. notion of self).

Although participants valued mainstream approaches in their therapeutic practice but they found Muslim interventions to be more beneficial in alleviating Muslim clients' problems or difficulties. Participants preferred to use Muslim approaches because (a) they identified a need for them for Muslim clients (b) they found them useful to address their Muslim clients' religious and cultural needs more effectively (c) they perceived these interventions were more meaningful to their Muslim clients (d) the use of Muslim interventions strengthened their therapeutic alliance (d) through the implementation of Muslim interventions they could communicate qualities such as congruence, enhanced empathy and understanding of Muslim clients' value system, whilst using these interventions as a tool to challenge their counterproductive belief system and bring about therapeutic change. Participants suggested that if therapists can establish a warm, welcoming, comfortable, and trusting environment for Muslim clients, where their context and values are respected, then they are more likely to remain in therapy.

Furthermore, obstacles experienced by Muslim clients in therapy were identified. Being treated by a non-Muslim therapist was avoided by Muslim clients due to the fear of being misunderstood and devalued for their religious beliefs. Some Muslim clients also feared that if they were treated by a Muslim therapist they may be indiscreet about the matters discussed out of the session. Participants further highlighted the ethical issues of dual relationship, biased and credibility issues. Participants suggested that there was a need to overcome these barriers. They advised professionals that whilst working with Muslim clients it was important to keep their religious, spiritual and collectivist context in mind. They further highlighted the need for a debate and dialogue among other

professionals about the integration of religion and spirituality into therapy, training and supervision for such integration.

Given their many uses and advantages, participants believed that if Muslim approaches were taught to therapists they could be beneficial for therapists and clients alike. They recommended that research should be carried out and information published on Muslim interventions and therapeutic models, to encourage their use by therapists with their Muslim clients. Finally all participants acknowledged that mainstream approaches and Muslim interventions are equally important, and a therapy that incorporates both would be more useful for Muslim clients.

5 DISCUSSION

Within this chapter, an overview of the relationship between the research questions and the findings is given. Implications of the findings for theory and practice are considered, as are directions for future research. The chapter ends with a discussion of the limitations of the current study.

5.1 OVERVIEW OF HOW THE RESEARCH QUESTIONS RELATE TO THE FINDINGS

Question 1: How are Muslim therapeutic interventions understood, experienced and administered in therapy by Muslim therapists with their Muslim clients?

Muslim therapeutic interventions that participants utilised in their therapeutic practice included exploration of religious and spiritual beliefs (e.g. life after death, P1-lines 751-752) and accepting and validating Muslim clients' complex beliefs (e.g. supernatural causes of mental health, P2-lines 218-229), and religious practices (e.g. prayers, P4-lines 202-205) for healing and growth. They further utilized Islamic notions of self in therapy with Muslim clients (e.g. P3-lines 322-326). Participants' experience when using these interventions was that they were relevant and beneficial when used in therapy with Muslim clients.

Question 2: How do Muslim therapists decide the suitability and usefulness of a Muslim therapeutic intervention for a Muslim client in therapy?

The participants' decision to choose Muslim interventions was informed by Muslim clients' religious, spiritual and cultural needs at the time of assessment, when the goal

and tasks of therapy were decided, as a shared decision between the therapist and the client. The use of the interventions that were congruent with clients' values and belief system, and through shared knowledge the therapeutic alliance might have strengthened, as Muslim clients stayed in therapy longer (P5-lines 249).

Question 3: What kind of challenges, if any, Muslim therapists encounter in the application of such interventions, and in what ways these interventions can contribute to counselling psychology.

Participants had a limited knowledge of Muslim interventions and mostly translated their Islamic knowledge into therapeutic practice. Participants also felt that there was sometimes a lack of awareness about the need to use religion and spirituality in therapy amongst professional colleagues (P3-lines 517- 528). Therefore they urged that there should be further training and research so that these models could be developed further, increase awareness in counselling psychology so that allied professionals could use these interventions to ensure appropriate mental health services for Muslim clients.

The findings will now be discussed in relation to existing literature.

5.2 MAINSTREAM PSYCHOTHERAPEUTIC APPROACHES FOR MUSLIM CLIENTS

Lago and Thompson (2002) state that therapists' initial training has a profound influence on their therapeutic practice. This is evident in this study as research participants' initial training in mainstream therapeutic models, including person-centered, CBT, and psychodynamic therapy formed a basis for their therapeutic

practice. Participants acknowledged that the psychodynamic approach helped them to explore a client's past and childhood experiences (P1-lines 62-65) and the person-centered approach helped to maintain a non-judgmental and empathetic attitude towards their clients (P5-lines 55-58). This shows that the psychological models learned in initial training had a profound impact on participants' therapeutic practice.

Participants were also aware that Western culture is different from Islamic culture (P6-lines 76-77) and they perceived that most mainstream psychotherapeutic approaches although not all are grounded in Western culture and the individualistic perspective, whereas, Islamic-Eastern cultural perspectives emphasise the collectiveness of family and community (P3-lines 128-130). Taking only the individualist stance with Muslim clients means that therapists are expected to focus on the interests of the clients, whereas in the Eastern-Muslim context it is not always about the client, it could be about the family or wider Muslim community to which the client belongs (P3-lines 128). Hence, Muslim clients might put their family wishes before their own. Participants therefore felt that using the Western individualist perspective might undermine and suppress Muslim clients' collectivist values (P3-lines 125-135).

This also seems to reflect Eleftheriadou's (2002) view that mainstream approaches such as client-centered therapy, widely used in the West, focus on the individual and their individual choices and freedom. Laungani (2004) further argued that the philosophy of individualism which may play a dominant role in Western thinking is of little value to people from other cultures. In Eastern cultures people tend to organise their private and social lives along communal lines, individual goals are often far less important than communal goals. Rassool (2015) therefore urged Muslim therapists to be aware that

counselling and psychotherapy conceptualised in Western, individualistic terms, are not always applicable to the needs of Muslim clients.

The British Psychological Society's (2011) Good Practice Guidelines on the use of psychological formulation also highlighted that there is a difference between Eastern perspectives on mental health and Western perceptive; and that should be taken into consideration when formulating clients' psychological issues,

> Western models of psychology and psychological therapy, and, therefore, the formulations that are based on them, often privilege ideas of independence and self-actualisation as indicators of good mental health, and focus on the individual as the basic unit of therapy. In contrast, non-Western cultures tend to focus more on notions of spirituality and communality and see the individual as secondary to the family (Webster, 2002). Mental health may not be seen as separate from physical, emotional and spiritual well-being, and there may be very different ideas about causation and intervention (Kanwar & Whomsley, 2011). Formulations may, therefore, need adaptation for use in a culturally appropriate way (p 18).

Alladin (1999) also criticised the Western concept of autonomous self and stressed the importance of respecting Muslim clients collectivist values by using an illustration quoted by Thomas and Althen (1989). A female Pakistani graduate student told her American female counsellor that she could not decide what to do about her abusive relationship with her husband until she had talked to her elder brother. This was seen as problematic by the therapist as she perceived the client as someone who could not make decisions and therefore needed to assert herself, since it was her life not her brother's.

The therapist explained this to the client. Unsurprisingly, the client left the therapy. Alladin (1999) urged that clients should not be stereotyped as being a particular kind of person, or for a behaviour to be abstracted from their context and culture.

Alladin (1999) further highlighted that with clients who hold a holistic conceptual system a therapist who is encapsulated in Western individualistic thinking is not only prone to misunderstanding the client but is at risk of forcing the client into a way of thinking that becomes a strait-jacket for them. He further states that it is hardly surprising if clients do not come back for therapy. It may then be misattributed to clients' lack of motivation or not being psychologically minded or ready for therapy when this may have been due to Western trained therapist's inadequate knowledge of Muslim clients' beliefs system or their potentially conflicting values.

However, it is important to note, that although both research participants and Muslim researchers asserted that mainstream approaches are insufficient to encompass Muslim clients' collectivist values, such generalisations may deem all mainstream approaches to being inefficient when this may not be the case. For instance, systemic approach works with clients' collectivist values and their family and social networks. It is also important to understand that collectivist values are there to provide individuals with support within their families and communities rather than to oppress them. For instance young Muslims can be pushed into forced marriage in the name of arrange marriage due to parents' dominant role in the families. Therefore therapists should address such conflicts and dynamics in therapy. Participants (P3-lines 109-113) also highlighted that the dominant interpretations of commonly held beliefs if counter-productive should be challenged in order to empower the individuals within their networks.

Participants also felt uncomfortable with the secular underpinning of most mainstream therapeutic approaches such as psychoanalysis and CBT (P6- lines 46-50). Participants stated that most psychologists in the West are apprehensive towards religion and spirituality (P2-343-347) whereas clients in therapy are not (P4-lines 810-813). Participants further noted that mainstream approaches are limited in helping to understand Muslim clients' mental health difficulties. Psychodynamics and CBT approaches only give a partial understanding of human beings due to their focus on cognitions, behaviour or childhood influences (P1- lines 48-51), whereas no indication is given "where cognitions fit in the concept of self, spirituality or the inner heart and how its related to the body" (P6-lines 95-96). The Islamic perspective is more holistic and comprehensive and includes the physical, spiritual, religious and psychological dimensions of human nature (P6-lines 76-79). Carter and Rashidi (2004) have also argued that Western psychotherapy deals inadequately with Muslim clients, as it does not capture their holistic understanding of mental health difficulties. It can be argued that it might have been influenced by the existing literature.

Again, participants' critique of mainstream approaches seems to be influenced by a widespread critique of its individualism and secularism. In reality there are approaches such as existential therapy which works with the spiritual dimension of clients and adopt a more holistic stance. Buber (1970) maintained that there are two types of relationships: the 'I-It' relationship and the 'I-thou' relationship, it is the later in which spiritual meaning can be found (West, 2000). Similarly, most humanistic therapists operate from a holistic model which sees people as physical, emotional, mental and spiritual beings. Also, as discussed in the literature review chapter, all major mainstream approaches including CBT have made efforts to incorporate religion and

spirituality in therapy. The research on such integration for Muslims is however limited (Koenig, 2009) and needs further attention.

All the above is relevant in the context of working with Muslim clients in therapy, as time and again researchers (Abe-Kim *et al*, 2007; Haque, 2008, 2010; Haque & Masuan, 2002) have asserted that the main limitation of mainstream therapeutic approaches is that they are not universally applicable and need to be adapted according to a diversity of clients. Despite increased attention towards more diverse and multicultural counselling services (Moodley & Palmer, 2014) and assertions about the limitations of mainstream therapeutic practice with Muslim clients, therapists in the UK including the research participants had been using mainstream approaches solely in counselling with Muslim clients. Some of the approaches, grounded as they are in individualism and materialism, can be incompatible and insufficient for use with Muslim clients if used on their own (Shah, 2005). Use of inappropriate therapeutic interventions can hinder or rupture a working alliance and deter Muslim clients from therapy. Nevertheless, over time participants recognised that Western theories and approaches had limited usefulness with Muslim clients. This led them to incorporate Muslim therapeutic interventions into therapy with Muslim clients.

5.3 THERAPEUTIC INTERVENTIONS FROM MUSLIM PERSPECTIVES

Participants' perceptions and understanding of Muslim therapeutic interventions seem to match that of Rassool's (2015) view that interventions from Muslim perspectives are religious, spiritual and cultural in nature (P6- 75-77). The use of Muslim interventions in therapy with Muslim clients was a collaborative decision between participants and their clients (P1-lines 349-551; P2-lines 615-619). Arthur and Collins (2010) have also

emphasised that the counsellor and client should work collaboratively in formulating relevant interventions; and clients' autonomy, choice, values and beliefs should be respected when administering spiritual interventions in therapy as recommended by Gubi (2007, 2009).

The Muslim interventions that participants utilised in their therapeutic practice included working with religious and spiritual beliefs and practices and Islamic notions of '*s*elf'. These will be discussed in relation to existing research.

5.3.1 Use of Prayer in Therapy

Prayer is considered the most commonly used religious practice for most Muslims. This can also be used in therapy for healing purposes (Tatsumura, Maskarinec, Shumay, & Kakai, 2003). Previous research has shown that prayer can have a calming effect, reduce stress, and help growth and healing in people in times of difficulty (Utz, 2012).

Most participants in the current study included daily obligatory prayers, recitation of the holy Qur'an, and Dhikr/Ziker (remembrance of God) or 99 names of Allah and Du'a (supplication) for healing purposes in their therapeutic work. This is in line with previous research, which shows these types of prayer can be used effectively for mental health difficulties (Ali & Aboul-Fotouh, 2012; Rahman, 2014; Utz, 2012).

Participant 1 used prayers such as the recitation of Surah Ar-Rehman (Qur'an: Ar-Rehman, 55) a Qur'an verse which manifests Allah's name (Rehman: The all merciful) for issues such as anger. She helped her client to develop an understanding of the Surah and reflect on the importance of gratitude and kindness in life (which is the message

conveyed through the Surah). This helped the client to forgive, facilitating the healing process (P1- lines, 698-799). Similarly, Suhail and Ajmal (2009) have reported that in some psychiatric wards of public and private hospitals in Pakistan Surah Ar-Rehman (Qur'an: Ar-Rehman, 55) was recited, and many clients had reported experiencing peace and well-being after listening attentively to this Surah. Hassouneh-Phillips (2003) study also reported that listening to Qur'anic recitation, prayer and religious meditation helped Muslim women recovering from partner violence and abuse as it comforted them and reduced their feelings of isolation by relying on Allah.

Similarly, participants felt that the use of prayer and supplication also facilitated a sense of hope (P2-lines 706) and resilience in Muslim clients as well as therapists by relying on Allah for clients' recovery (P4-lines 422).

5.3.2 Health Beliefs (e.g. Punishment or a Test, Life after Death)

In the findings of the current study it was evident that Muslim clients' health beliefs included religious, spiritual and cultural aspects to explain the causes of mental health difficulties and how healing can be acquired. This had a significant influence on research participants' therapeutic practice with Muslim clients. According to participants, most Muslim clients viewed mental health difficulties as punishment for their wrong doings (P1-lines 369-370; P2-lines 133). Badri (1997) stated that Muslim clients who come from families with an exaggerated sense that Allah might punish them sometimes experienced guilt, regret and anxiety. Due to such beliefs Muslim clients may develop a passive attitude towards their healing (Ali et al, 2004). Participants highlighted that Muslim clients may then develop more complex psychological

problems such as low self-esteem, guilt and anger towards others, self and God (P2-lines 254).

On the contrary a belief that difficulties and hardships could be a test and would be rewarded by Allah could give clients hope and self-confidence (Abu-Ras & Abu-Bader, 2008; Rassool, 2000). This can also reinforce positive behaviours and an active stance towards their difficulties and readiness to utilise coping strategies such as prayers facilitating recovery (P1- lines 393). This may also help to reduce their anxiety and depression and encourages compassion for forgiveness (Hamidi, Makwand & Hosseini, 2010).

It was also suggested that Muslim clients in therapy should be helped to alter these thoughts and beliefs (Badri, 1997). Correspondingly, participants seem to have helped their clients to alter these counterproductive health beliefs. These included mental health difficulties seen as punishment to be viewed as a test or trial that would be rewarded in the next life (P2-lines 134).

This was expressed by participant 5 who was able to incorporate the client's beliefs about the reward for being patient in life after death with a Muslim client, for bereavement issues (P5-lines 219-229). The participant felt that the belief in life after death gave the client hope that her child was in heaven and that she would join her in her next life, and her patience would be rewarded by Allah. This is in line with a Mehraby (2003) study as discussed in the literature review (chapter 2) showed Muslim belief in destiny, reliance on Allah, life after death and patience can give comfort, resilience and strength that facilitate healing in accepting loss. She helped her clients to

alter their unhealthy belief in 'being punished' to the one that Allah will reward them for their patience. It can be argued that Mahraby (2003) and participant 3 were using a cognitive restructuring technique, which is a mainstream psychological intervention. However, exploration of these beliefs facilitated an access to territory within the client's world of meaning that was more responsive to the application of that technique.

The participants' own journey with religion and spirituality not only helped them to grow on a personal and spiritual level but also helped them to show empathy towards their clients and develop a better understanding of their struggles (P1-lines 476-481). Participant 3 stated that it was vital for her to have had this journey to understand her clients: "for me to be able to work with clients on their religious beliefs, I have to have made a journey into that area myself" (P3-lines 180-181).

Participants being Muslims had been exposed to, and had the opportunity to use Muslim healing and coping strategies in times of difficulty. Participant 1 had practiced recitation of the Qur'an for her relationship difficulties which helped her to manage her anger, to forgive and move on (P1-lines 698-701). She then used it for her client to manage anxiety (P1-lines 664-665). Participant 4 also stated that through her own spiritual journey and development she had recognised that spirituality healed her psychologically and spiritually (P4-line 40-41).

The ethos of counselling psychology also urges therapists to experience therapeutic techniques themselves in order to gain confidence in the power of the therapeutic process and the usefulness of the underlying theory (Macran, Stiles, & Smith, 1999).

5.4 BARRIERS TO THERAPY

The research participants identified some of the barriers that Muslim clients encounter in therapy. Stigma is considered the most significant barrier to accessing the mental health services due to the shame of disclosing personal and family issues to outsiders (Youssef & Deane, 2006). Participants also seemed to agree that stigma is the main reason for Muslims and non-Muslims to fail to seek therapy (P5-lines 344-345).

This is line with Pilkington, Msetfi & Watson (2012) study that looked into the reasons for and barriers to Muslims seeking and continuing psychological help. They reported that the level of shame/izzat/stigma, were significant factors affecting intention to access psychological services by South Asian Muslims in the UK; other factors included acculturation, education, and beliefs as to the cause of mental health difficulties. The study has only focused on Muslims from a South Asian background; a population that is less likely than both the general population and other ethnic minorities to utilise mental health services (Sheikh & Furnham, 2000). The findings however are consistent with another more recent study (Ciftci, Jones & Corrigan, 2013) which reported that even Muslims with a positive attitude towards mental health healing are concerned about disclosing mental health problems and considered it 'shameful' and that it would affect the family social standing.

Amongst Muslim there was also a fear of having religious, spiritual or cultural and familial values undermined (P3-line 124-130). Participants stated that Muslim clients felt apprehension consulting non-Muslim therapists or they didn't feel comfortable expressing their religious or spiritual concerns (P4, 827-829).

Loewenthal's (1995) study examined the relationship between peoples' beliefs and help seeking attitudes in the UK and concluded that ethnic/religious communities fear being misunderstood by mainstream trained therapists with regard to their cultural and religious practices, and therefore they found it easier to talk to professionals with whom they shared a common group identity. Qasqas and Jerry (2014) further highlighted that the lack of understanding and information about Islamic beliefs might lead to biases in therapy with Muslim clients and this may hinder an effective working alliance or evoke mistrust in Muslim clients (Hussain, 2009).

The present analysis further discloses that a barrier to therapy with a Muslim therapist for Muslims clients was fear that confidentiality may be breached, and people from their community would discover their mental health difficulties, with repercussions on their reputation, status of the individual within the family or Muslim community, difficulties finding jobs, or affecting their marriage prospects (P5-lines 343-345). This is consistent with Tabassum, Macaskill, & Ahmad (2000) study which highlighted Pakistani Muslims in the UK particularly women were frightened of the negative consequences of help seeking, specifically with regard to prospects of marriage or creating problems in a current marriage. The implications of these barriers to therapy will be discussed in the next section.

5.5 ETHICAL CONSIDRATIONS AND IMPLICATIONS FOR TRAINING AND PRACTICE

While acknowledging the many uses and advantages of incorporating Muslim interventions into therapeutic practice, participants expressed some ethical concerns

such as credibility, bias and the dual relationship issues. They also pressed on a need for training and supervision.

All the participants were concerned that there was a lack of training as they were mainly relying on their basic knowledge of Islam or a basic level of training in Islamic knowledge (P2-lines 440), leaving participants concerned about their competency for incorporating religion and spirituality in therapy (P1-lines 317). They also experienced difficulty finding appropriate supervision for using Muslim interventions; consequently they were seeking guidance from Islamic scholars as discussed by participant 2 (P2-lines 510-513). Dually trained psychologists also face unique challenges. The intellectual and philosophical bases of religious training fit imprecisely with the scientific traditions of psychology, requiring extra care in transferring this knowledge into therapeutic practice (Gonsiorek el al, 2009).

The role of the Islamic scholar as a mentor is complicated because discussing clients' issues with someone who is not qualified, experienced and "registered with a professional or statutory body which has a code of ethics, and accreditation and disciplinary/complaints procedures" (British Psychological Society, 2010b; p 2) would not be ethical. Therefore, participant 2 urged for a supervisor who is trained in both therapeutic traditions and is a qualified supervisor (lines 510-513). Participants who had already developed Islamic counselling models and training programmes also stressed that there should be more debates, discussions, training and research in order to develop a deeper understanding of Muslim therapeutic interventions (P3-lines 699-703).

This is in line with solution proposed by Gonsiorek el al. (2009) that sufficient competence in spiritual and religious issues in psychology should resemble competence in other areas of expertise: a sufficiently broad and detailed combination of course work, supervised experience, continuing education, professional reading, consultation, and other standard training is required. Through appropriate education, training and supervision even non-Muslim psychologists could gain competency to work with Muslim clients; this will minimize the assumption that clients are best treated by therapists who are similar to them (Gonsiorek el al, 2009). Muslim clients sometimes felt reluctant to consult 'Muslim therapists' as they were concerned about their confidentiality (P5-lines 334-336). Training non Muslim therapists will help these clients since counselling psychology profession tries to promote a competency-based, not affiliation-based, norm for client-therapist matching (Gonsiorek el al, 2009).

Considering that Muslims are the largest religious minority in the UK, and they are underserved in mental health services despite there is a growing need further training in Muslim interventions on counselling psychology courses will therefore benefit a larger community that is under threat due to current state of Islamophobia. However, it may be argued that unless the competence is limited to a particular religion, therapists will have the same challenges as do other psychologists in developing competence in other religions. Due to the limitations in funding, and time constraint within counselling psychology training programms, it may not be possible to provide training to incorporate all religions and cultures. Clinical supervision, continued professional development (CPD) and further research by counselling psychology trainees could counter this.

Another ethical concern expressed by the participants was negative bias towards spirituality and religion amongst other professionals. For instance, some non-religious professionals do not give clients' religiosity and spirituality enough significance, or perceive that incorporating spirituality is incongruent with the scientific nature of psychology; or consider psychologists who incorporate religion into therapy as doing this for their own rather than clients' needs (P3-lines 522-523). Negative bias on the part of clients towards non-Muslim therapists was as lacking understanding in Muslim belief system (P5-lines 333-334). Similarly, the perceived bias towards Muslim therapists was as not being competent enough to deal with spiritual issues in therapy (P1-lines 317).

A potential positive bias on the part of Muslim therapist for a Muslim client might be to expect that all Muslim clients want a religious form of therapy: this may be untrue and should be clarified at the time of initial assessment. Similarly clients with a Muslim therapist may have high expectations about therapy outcomes and want a magic cure expecting that a therapist using religious interventions can work miracles (P1-lines 340-345). This also raises dual relationship issues. To counter this issue, it can be suggested that in a challenging nascent area, holding up standards of psychological tradition can be helpful to ensure ethical practice. Maintaining psychology's standards however is a complex undertaking as it involves specific practice challenges (e.g. dual relationship) because expected boundaries can operated differently in religious traditions. For instance, participants who were using religious interventions were expected to take responsibility for a clients' recovery much as clients would expect from the clergy would perform certain rituals, and the problem would then disappear. Whereas

therapeutic work is very different and requires hard work, patience and motivation on part of both therapist and client.

These dilemmas may have led participants to reflect on the ethical implications of their clinical practice. Some of the reflections about their efforts to ensure the ethically sound integration of Muslim interventions will be discussed in relation to therapeutic alliance in the next section.

5.6 THERAPEUTIC ALLIANCE AND IMPLICATIONS FOR THERAPY

The therapeutic alliance has been seen as an essential ingredient of therapy (Gaston, 1990) and a significant predictor of therapy outcomes (Martin, Garske, & Davis, 2000; Meier, Barrowclough, & Donmall, 2005). It was found in the current study that having a shared understating of Muslim clients' religious and cultural beliefs enabled participants to empathise that made their clients more at ease, less defensive and strengthened the therapeutic relationship (P2-lines 276-278). Understanding clients' values and worldviews also guided the process of adopting an appropriate treatment plan that made the therapeutic process more meaningful for clients (P1-lines 392-395).

According to Bordin (1994), the working alliance strengthens when there is agreement on the goals of therapy between the counsellor and the client, the tasks that need to be accomplished in order to achieve those goals, and mutual respect and trust. Qasqas and Jerry (2014) further highlighted that mutual respect and trust could not be achieved without acknowledging clients' cultural and religious belief system; therefore awareness of these belief systems is crucial to establishing a strong therapeutic relationship.

Based on the above conditions for a positive working alliance, Arthur and Collins (2010) described three main competencies for the therapists which have also been identified by the therapists in the current study, i.e. awareness of the client's culture and religion (competency 1; P3-lines 54-65), working collaboratively with clients to identify and set mutually agreeable and appropriate goals (competency 2; P2-lines 263-265) and tasks to achieve those goals (competency 3; P2-lines 614- 619). Correspondingly, through the use of Muslim interventions participants were capable of showing an in-depth understanding of Muslim clients' beliefs, investigating and incorporating spiritual, religious and cultural realms into the goals and tasks of counselling which strengthened their working alliance with their clients. Therefore they were not only able to show empathy towards their clients' complex belief system but also utilised interventions (e.g. religious beliefs and practices) that were relevant and congruent with their values facilitating change.

There are many formulations and theories about how the therapeutic alliance may improve therapy outcomes across psychological approaches which is beyond the scope of this study. The nature of the therapeutic relationship between participants and their Muslim clients seems to have a similarity with Rogers' (1951) view that therapeutic relationship is not a process in which a therapist tries to find out what is wrong with the client (patient), instead, the person seeking change takes an active position in the process. He further stressed the potential healing power of the therapeutic alliance. Bordin (1994) further suggested that the therapeutic relationship might serve as a model for an improved relationship with self and others, which in turn may improve therapy outcomes (Bordin, 1994). Having mutually understood goals, they also help forge bonds of trust and respect where clients feel that the therapist is listening carefully and is

sensitively to their spiritual and cultural needs, which gives them confidence and a sense of safety to explore more complex psychological processes that may then facilitate change (Bordin, 1994).

Furthermore, a therapeutic relationship between Muslim clients and therapists provides a spiritual space that may help them to improve their connection with their creator enhancing their sense of hope, resilience and meaning (P2-lines 371-373). Reliance on Allah may give Muslim clients a sense of indirect control over the circumstances, reducing the need for personal control (Koenig, 2009). Similarly for a Muslim therapist reliance on Allah may feel very liberating and put them on ease about therapy outcomes and help them to be more present in the therapeutic process (P1-lines 582-584). The therapeutic relationship demonstrated by participants is also in line with the social constructionist view, which will be discussed in detail in the next section.

5.7 SOCIAL CONSTRUCTIONIST PARADIGM AND MUSLIM THERAPEUTIC INTERVENTIONS

Social constructionism held a significant place in the findings because participants held the view that clients were influenced by their social, cultural and religious context (P3-lines 52-65). This idea of self seems to be relevant to the post-modernist's social constructionist's view on self, which challenges the contemporary view of the self, seen as a separate entity from the social world (Burr, 2015; Lyddon, 1998). The self in the social constructionists' view is understood as interpersonally constructed and constantly being redefined moment-by-moment within each social interaction (Neimeyer, 1998). Furthermore, Lyddon (1998) also suggested that the self can be influenced by culture and political context.

The Islamic notion of self is embedded in the collectivist worldview for Muslim clients. As participant 3 puts it; it is a "socio-centric notion of self" (lines 326). She further states that self is not perceived as individualistic as it might be in the West (lines 323). This also seems to have influenced the participants' own positioning in their practice because instead of isolating psychological problems within the client, taking a social constructionist view showed how their distress cannot be separated from the social processes and context in which they exist.

From a social constructionist viewpoint, the social construction of knowledge is mediated through language. Language is not merely a reflection of thought and feeling within individuals, but also a tool for social action (Burr, 2003). It highlights certain features of the world and once accepted in common use, it alters how individuals perceive the world. Hence, how people describe their experiences transforms what their experiences are (Sandage & Hill, 2001). This was evident in participants' use of shared language and the way they helped their clients to alter the meanings.

Muslim therapeutic perspective focuses on harnessing a client's positive resources and growth and not merely alleviating pathology (P2-lines 872-876), a common perspective shared by social constructionist perspectives on psychotherapy (Sandage & Hill, 2001). Since language is viewed as influencing the realities by which people live (Neimeyer, 1998), Muslim therapists creatively employ the metaphor and shared language to create new meanings concerning clients' experiences. The identification of new meanings reshapes clients' present understanding of their identity and experiences, for instance, from perceiving oneself as a person who is being punished to one who is being tested by Allah and from the one who is depressed to the one who desires to be more courageous.

Furthermore, it has been highlighted that the use of shared language forms a collective identity as it becomes symbol of group identification and distinctiveness (Jaspal & Coyle, 2010). Speakers come to feel connected through their common use of the language forming and strengthening the basis of a cohesive collective identity. It has also been suggested that members of religious group tend to share similar social representation of the norms and practices associated with their religious identities; this may include the use of language (Jaspal & Coyle, 2010). As Jaspal and Coyle (2010) argued it might be employed as a tool to strengthen the sense of community and 'oneness', this might have been the reason that both Muslim clients and participants felt a deeper connection when using shared language.

The nature of the therapeutic relationship between participants and their Muslim clients can also be explained through the social constructionist approach. Participants considered the relationship between client and therapist as paramount (P5-lines 258). Other Mainstream approaches such as client centered counselling also acknowledges that the relationship between therapist and client is at the heart of the therapeutic encounter. However, Alladin (1999) argued that in mainstream counselling, the counsellor or psychotherapist as expert unknowingly perpetuates a medical model whereas the constructivist approach underpins the Eastern healing systems such as the relationship between the guru (teacher) and disciple (pupil). Rudes and Guterman (2007) have argued that constructivism has revised the notion of 'cure', a concept that still underpins the biomedical and behavioural paradigms which consider that an expert can fix, cure or change the disorders or maladaptive behaviours or dysfunctional cognitions and thus alter the client/patient.

Gutterman (1994) further argued that social constructionist paradigm challenges the notion that the therapist is an objective expert on clients' issues. Gutterman (1994) stressed that in the constructivist approach there are two people trying to understand how at least one of them construct his world. Greater attention is paid to clients' subjective views of his difficulties and wellbeing. Instead of the therapist actively dispensing professional knowledge to the client, psychotherapy is one of the joint meaning making process between two people (Gergen, 2001). Thus this changes the role of a Muslim therapist from the medical position of one who cures to the more spiritual posture of one who guides or helps construct conditions for change through his or her own spirituality (Carlson, Erickson & Seewald-Marquardt, 2002).

However, there is a question as to whether this may cause a power imbalance or risk of imposing values. This was clarified by Laungani (2004) who considered therapy as a partnership where there is inevitably a power imbalance and the lead is taken by the therapist but for the purpose of guiding the client. The social constructionist paradigm challenges the notion that the therapist is an objective expert on client difficulties (Gutterman, 1994). Alladin (1999) suggested that as the therapist might be expert in psychotherapy, but the client is the expert on himself and has the privilege to question, disagree and challenge the therapist's interpretation of his concerns. This is the position held by participants in their work with their Muslim clients; they helped their clients' personal and spiritual growth.

However, it is important to consider that the study takes the moderate relativist position and takes beliefs and internal process into consideration. Taking the social constructionist stance does not deny the importance of personal agency, which is, one's

free will, ability to act and make choices voluntarily (Burr, 2015). One may criticise the social constructionist view for if social and linguistic forces, rather than psychological structures such as beliefs, values, or attitudes form personhood, the concept of personal agency appears illusory. This view was clarified by Gergen (2001); who pointed out that there are two categories: strong and moderate social constructionism. Proponents of strong social constructionism embrace relativism as well as a socially and linguistically determined view of selfhood that pays little attention to the notion of personal agency (Neimeyer, 1998). The current study embraces moderate social constructionism which views language as not the creator but conveyor of meaning (Terrell & Lyddon, 1996), and recognises the importance of personal agency alongside the social construction of personhood (Burr, 2015). It takes a stance that knowledge and truth are influenced but not exclusively determined by social and linguistic structures.

5.8 RELEVANCE TO INDIGENOUS PSYCHOLOGY: BRIDGING THE GAP

All participants identified Muslim interventions as most appropriate for Muslim clients because it is in accordance with Muslim clients' worldview, however, they do not seem to use Muslim interventions in their entirety. It seems that these interventions were used in conjunction with mainstream approaches. Participants started incorporating Muslim interventions to address the gap that they perceived in their therapeutic practice when working with Muslim clients. All participants however valued both the approaches equally.

As participant 2 has reflected, "it has to be two prone approach […] one without the other is, it works but it's less effective than both at the same time" (P2, lines 331-333). So it seems that participants have used their own understanding and knowledge of

Muslim and mainstream approaches and models to modify and improvise their practice to suit their Muslim clients. In this way, they began to combine both approaches to form an integrated indigenous approach. Indigenous psychology evolved into a worldwide response to the assumption of universality of psychological theories (Haque & Keshavarzi, 2014; Kim & Berry, 1993). Kim and Berry (1993) define indigenous psychology as "the scientific study of human behavior or mind that is native, and that is designed for its people" (p 2).

Enriquez (1993) identified two types of indigenous psychologies: Indigenisation from without and indigenisation from within. The *Indigenisation from without* approach involves modifying psychological theories, concepts and methods and integrating them with the local knowledge and the indigenous knowledge is treated as auxiliary and not as the primary source of knowledge. Participant 2 provides an illustration of this, "Allah has given you the power […] to reframe and change thoughts, which is basically CBT; is extremely powerful" (lines 478- 481).

She has been using CBT in conjunction with the Islamic beliefs system. Similarly participant 1 reflected on her practice of combining the two, "God is punishing me is there another way of looking at this […] opening the mind to alternative hypotheses straight CBT anyways" (lines 377-381). In this manner, participants' were able to indigenise CBT with their understanding of Islamic beliefs system to make it more applicable, relevant and meaningful for Muslim clients. Similarly, Participant 2 has indigenised mindfulness practices with Islamic prayers such as Zikr, "if within mindfulness we incorporated for example Tasbeeh (Zikr), he is very mindfully and peacefully doing some Zikr" (P2, lines 658-661).

In indigenisation from within, concepts, theories, and methods are developed internally even if there are imported components (Naidu, 2002), and indigenous concepts are considered the primary source of knowledge (Enriquez, 1993). Participant 6 seems to resonate with that as he perceived that the Islamic notion of self used in his practice with Muslim clients is very unique, "the concept of self and personality is quite different the way it has been described by Muslim philosophy as compared to Western philosophy" (lines 83-85).

Furthermore all the participants believed that therapeutic interventions have to be based on the clients' worldview and their context. Depending on clients' beliefs system and context, they would work and relate to them differently. So they would adapt their practice and language accordingly. All participants adapt their language to suit their Muslim clients, "the language is often used very very differently […] its incredibly powerful" (P2, lines 53-54). A similar stance Participant 3 seems to have taken in her practice "So it was like speaking someone's language in a way that makes sense" (lines 134-135). Participant 6 believes that psychotherapeutic interventions or techniques have to be based on clients' needs and their context. Depending on who they are and where they come from, participants would work with them and relate to them differently. So their practice would change to suit the client. This seems to be in line with the ethical principles laid by the BPS (2009) that recommend that "psychologists should respect individuals, their culture, age, education, language, and national origin" (p 10). So in contrast, when participants work with Western clients, they revert to more Western style of communication.

However, participant 4 was adamant that she uses Islamic counselling in its purity, “they come up with a cliché but it's not deeply Islamic, this is very deeply Islamic. So all of the underpinnings, everything that we do is spiritual” (lines 397). She also states “its absolutely fine to use any model and any technique as long as it sit with as long as, they are filter through the Islamic teaching” (lines 311-313). She believed in the globalisation of knowledge (lines 297-310) which means we have to make use of all the approaches regardless of whether their origin is in the East or West as she also believed that without Western knowledge she would not be able to work effectively with Muslim clients living in the West. This shows her tendency to have used knowledge from both traditions: Muslim and Western, thus indicating that she also may have worked indigenously.

So far, it can be stated that participants have engaged in indigenous practice at theoretical, personal and/or relational, and contextual levels with Muslim clients. Thus it is important for practitioners to recognise what their Muslim clients want from therapy and devise interventions that can help achieve these goals ethically. This may mean integrating Muslim mental health beliefs with the CBT approach for a Muslim clients dealing with issues such as bereavement. It is important to take both their traditional values and current context of living in the West into consideration, and therefore offer them a therapy that incorporates both: the scientific principles of psychology and traditional Muslim healing beliefs and practices. A more compressive and holistic approach needs be adopted by incorporating both approaches into therapy with Muslim clients.

5.9 FURTHER IMPLICATIONS FOR THERAPY

A point that was hopefully emphasized throughout the entire research was that practitioners should choose therapeutic interventions that are congruent with Muslim clients' values and beliefs system taking their context into consideration. Using these interventions in conjunction with mainstream therapeutic approaches may be more useful for Muslim clients in therapy. The study has demonstrated that therapeutic interventions from Muslim perspectives implemented by Muslim therapists were relevant to Muslim clients' religious and cultural context and can foster the therapeutic alliance. Thus, healing can be facilitated for Muslim clients within this spiritual and psychological space.

This IPA study should impact practice by providing qualitative experiential information from the participants accessible to other health professionals working in similar situation. It also provides empirical evidence for some topics less widely discussed such as the experience and perception of Muslim therapists using Muslim interventions and their impact on the therapeutic alliance and consequent therapy outcomes. Further, this would subsequently result in reflections and discussion within counselling psychology and other therapeutic practices to understand the need of exploring religious issues in therapeutic work with religious clients.

5.10 CRITIQUE OF THE PRESENT STUDY

The trustworthiness of the findings might be brought into question because it would be difficult to generalize due to subjectivity involved during interpretation. Generalisibility was not the major concern for this study. The researcher was however aware that a process for ensuring the trustworthiness of qualitative research is essential, hence a

framework proposed by Shenton (2004) was employed (as discussed in section 3.5) to inform the key research decisions safeguarding against issues that would bring the trustworthiness of this study into question.

There was the possibility of researcher bias during analysis. As a Muslim therapist, researcher was aware that her preconceived ideas, understanding and expectations might colour the results of the study. Efforts were made to guard against this, the methodology chosen allowed the researcher's own perspective to be inherent in the process. However, as is suggested by Willig (2008), instead of attempting to bracket her presuppositions and assumptions about the phenomena under study, researcher tried to work with them and use them to advance her understanding.

Another potential limitation, although well debated in previous research, was the use of only six participants, although they were interviewed in-depth about their experiences. As the aim of this study was to investigate in-depth experience of participants, a small homogenous sample was necessary (Smith et al, 2009).

The study did not aim to produce widely transferable findings, and it is recommended that the findings be used to inform a larger study investigating a more widespread population of Muslim therapists. Also future study examining the in depth experiences of Muslim clients who have experienced Muslim interventions should be conducted to match the credibility of the usefulness of these interventions.

5.11 CONCLUSION

The current study was designed to investigate the experience of Muslim therapists using Muslim therapeutic interventions and their understanding of the usefulness of these interventions with Muslim clients in therapy. The findings lead to a number of conclusions. Muslim therapists felt that incorporating Muslim interventions into their therapeutic practice enabled them to address their Muslim clients' religious and cultural needs more effectively. Muslim therapist through the implementation of Muslim interventions can communicate qualities such as congruence, empathy and understating, whilst using these interventions as a tool to challenge and bring about therapeutic change and growth in Muslim clients. Muslim clients may have preference for a Muslim therapist due to potential shared experiences, language and understanding.

Moreover, using Muslim interventions with Muslim clients is a need in the current state of Islamophobia as by utilising Muslim interventions, Muslims clients' fear of being misunderstood could be eased if they felt their values were being undermined or stereotyped by a therapist who did not have knowledge of their value system. Also, the client may be more receptive towards the use of the interventions coming from their own religious and cultural background and may stay in therapy for longer.

Although mainstream approaches and the Muslim healing tradition both have strengths and weaknesses to overcome, both are equally useful for Muslim clients. Using both mainstream and Muslim interventions may be a way forward into working effectively with Muslim clients who are living in the West, and can benefit from both traditions according to their goals in therapy. The study has urged to move beyond the assumption

of a sharp dichotomy between Muslims and Islam and the West. Instead there is a need to study Muslims and Islam 'in the West' (Malik, 2009).

The findings of the current are also consistent with the existing literature (e.g. Haque, 2004b; Hodge & Nadir, 2008; Inayat, 2001; Kobeisy, 2006; Mehraby, 2003; Rassool, 2000), which indicate that utilisation of Muslim therapeutic interventions in therapy is Muslims' preference and seems a promising way of meeting their needs.

Therefore, it can be argued that Muslim therapeutic interventions are worthy of investigation, and that they may have a lot to contribute towards the development of counselling psychology practice and research. Coyle (2010) has highlighted the possibility of a mutual relationship: counselling psychology can also make important contribution to religious and spiritual interventions. The findings have also highlighted the need for training in using Muslim therapeutic interventions in counselling practice to ensure that clients' context will be taken into consideration when working therapeutically.

6 CRITICAL APPRAISAL

The critical appraisal charts my journey through the research process and shares the summary of my research journal. The aim is to make my experiences, expectations, views and feelings visible and an acknowledged part of the research design, data gathering, analysis and interpretation process in order to engage with the notion of creating transparency and to explore the impact of critical self-reflection on the research process.

The Professional Doctorate in Counselling Psychology training requires trainees to be in personal therapy. I began the therapy with a counselling psychologist who was white British. The therapist was sensitive and respectful towards my cultural and religious values and beliefs. Initially, I felt comfortable sharing my religious or cultural beliefs with her due to her openness and willingness to explore them in the session. However, as therapy progressed I started to notice her limitations of dealing with my religious issues.

I felt this was a burden to her and she was out of her depth trying to understand the complexity of some of the cultural and religious issues that I brought to therapy. Although I understand that a client is an expert on his or her predicaments and should make an effort to make the therapist aware of them, it is ultimately the therapist's responsibility and a professional obligation (Health & Care Professions Council, 2015) to educate her/himself about the clients' cultural and religious context. I became disconnected from my emotions as I spent time explaining. It also started to affect our therapeutic relationship.

With time my training became more demanding, it was challenging for me as I was trying to manage my young family at the same time. It had become a juggling act. Self-care was a crucial need and I thought therapy was the best avenue to help, but on reflection I realised that the resources I drew on most at this time of turmoil were my religious and spiritual beliefs and practices. As a child I had learnt to pray five times a day to seek Allah's help and be patient in time of distress, and practice Zikr in order to restore peace and calmness.

Although it was very valuable to see the psychological component of the stress in therapy, I felt my healing was largely facilitated by my religious practices, which made my distress and struggle more meaningful. I also found that the religious practice gave me a greater capacity for personal healing and growth by making me more resilient and stronger and I wished I could explore this further in therapy.

At the time I was studying mainstream psychological approaches and their theoretical underpinnings, including existential and psychodynamic approaches. I began to feel disappointment at some of the anti-religious assertions of the founders of these theories that had created a divide between religion and psychology. Most disturbing for me was to engage with Nietzsche's (1974) anti religious thoughts.

My lecturer, when I asked for a clarification, stated that she was an atheist and did not have much interest in religion. It was very unsettling for me, and I had begun to doubt my passion for existential philosophy. I was confused and muddled and I ended up doubting myself, "is it right for me to study such psychological theories", "can I talk

about these theories in the Muslim community and will that be accepted or respected" and "if I use these approaches in therapy will that suit to my Muslim clients' needs".

I reflected on the conflicting dynamics of what I was learning from these theories and what was happening for me in real life (in terms of religious coping). I started to think that Muslim clients and psychologists might experience the same dilemma. Questions such as: how did Muslim therapists work with Muslim clients, did they work differently, if they did, what interventions did they use in order to make it more appropriate and meaningful for Muslim clients in therapy started to emerge.

On reflection, I thought that we don't acquire knowledge passively, we engage with it, and by doing so we actively create our own realities. So I decided not to accept religion and psychology as conflicting domains. I had also learnt that knowledge does not exist in a vacuum and there is always a context in which knowledge is generated. Religion seen as dogma and something that should be got rid of was a Western construct from the time of battle against the church. With the current state of globalisation, there is need for East and West embracing each other. With this in mind, I then began searching through literature looking at the relationship between religions and the spirituality and psychology in the West. I found evidence showing that despite the unease between religion and science in the past, the relationship had started to change and there is now growing recognition of a positive relationship between mental health and religion and spirituality in the West (Coyle, 2010; Haque, 2001).

Further reading on Muslim mental health however revealed several criticisms about the mainstream approaches as being Westernised, Eurocentric and individualistic, and

therefore not appropriate for Muslim clients in therapy. There were suggestions about using interventions appropriate for Muslims. Only a few empirical studies had been conducted supporting evidence for these interventions as compared to the assertions made by researchers about the usefulness of Muslim interventions. Furthermore, most of the traditional healing practices are ancient and need to be developed so they can be applied appropriately to the needs of Muslim clients in today's context. This made me think about conducting research exploring therapeutic interventions from Muslim perspectives, and the starting point of this research project was conceived.

The idea of conducting research on Muslim interventions received a mixed reaction. One of the lecturers asked me whether doing research from a religious perspective would have any credibility in psychology. I was however aware that there has been a major upsurge of interest in spirituality within counselling psychology more recently (Coyle, 2008; Swinton, 2001), and counselling psychology embraces diversity in research and practice. I started putting the idea across in discussions with my colleagues, and I felt my co-trainees both Muslims and non-Muslims were fascinated and wanted to know more about Muslim perspectives on self and healing.

This enhanced my confidence to go ahead with the idea, and that there might be acceptance amongst the new generation of counselling psychologists who are more open to the idea and understand the need for multi-faith and multicultural therapy for their clients. The mixed reaction about marrying the two disciplines broadened my research question to what challenges the Muslim therapists might have when employing these interventions in their mainstream therapeutic practice in the UK.

I wanted in-depth views about Muslim interventions. This demonstrated to me that the topic was already taking on a phenomenological epistemology, so I decided to use an IPA methodology to analyse the interviews (Smith et al, 2009). The methodology also felt congruent with my theoretical and therapeutic stance of using an existential-phenomenological approach with clients.

My research was going to be primarily based on interviews; therefore the interview schedule was the main tool of data collection. Equally I had a crucial role to play. I started out reading the literature on the role of researcher as interviewer, and about the notion of reliability, validity and objectivity (Glesne, 2015; Patton, 1990). Given my personal and professional investment in the project, I realized that reliability and objectivity could not be achieved in its traditional terms. I was a Muslim and all of my research participants were Muslim too with similar knowledge of Islamic therapeutic interventions that I might have. I realized that I was not neutral about the research project from the onset. I had knowledge of Muslim therapeutic interventions. I also had desires for the project and what it would achieve, or discover that were bound up with my views.

It was therefore difficult to be objective in the process. I then read more about trustworthiness in qualitative research and acknowledged the process of subjectivity as Giorgi (2002) stated that within phenomenology, the goal is not to eliminate subjectivity but to clarify the influence of subjectivity. By taking up Scheurich's (1997) proposition of making the 'baggage' that we bring to the research visible, I tried to make my history, values and assumptions open to scrutiny, not as an attempt to control bias, but to make it as visible as possible to the reader. From the introductory chapter I

have discussed my background and positioning throughout. This is also the aim of the current chapter.

In terms of the impact of reflective research, I became aware of my own desire, expectations and views about the research and the possible impact on the construction of interview questions and conducting the interview. I therefore worked closely with my supervisors and drew on the insight of peers, particularly those who were non-Muslim. For instance, my supervisors pointed out that my views about Muslim interventions might have been influenced by the assertions made about their uses in previous literature. This helped me to take a more critical stance towards the existing literature and focus more on evidence based knowledge. Supervision and discussion with fellow researchers also helped me to reshape my interview schedule, provided more clarity in my writing and helped me to develop a more critical stance throughout.

Initially, I wished to recruit only counselling psychologists as participants, concerned about the study's position in relation to counselling psychology profession. However, after screening the profiles of Muslim therapists in the UK who were offering therapy from Muslim perspectives, I foresaw that I might find difficulty recruiting enough participants if I restricted the criteria to a counselling psychology background only. This proved correct as after having spent months searching for prospective participants through online counselling directories and organisations like the BPS and Muslim counselling organisations, only one counselling psychologist agreed to participate.

It is interesting to note that many counselling psychologists were identified by their Muslim names from the BPS chartered register and were contacted but only one agreed

to participate. Does this suggest that Muslim counselling psychologists do not use Muslim interventions in their practice or do not show interest in taking part in the research process? Does this have anything to do with their level of comfort or confidence when using these interventions or when talking about it? Although it is not in the scope of this paper to explore these questions in depth it might be worth investigating further.

Fortunately the participants who were not counselling psychologists had a substantial amount of experience and knowledge of working with Muslim clients in therapy. Three of my participants have already endeavoured to develop an Islamic/Muslim model of counselling. Their contribution to this research is valuable regardless which professional background they came from, and may nevertheless be beneficial for Muslim clients in therapy.

I found myself more comfortable in the interview process when interviewing participants with a similar identity to mine, having a shared understanding of Muslim beliefs and shared language, which put me at ease. Along with this, however, came a sense of 'wanting to get it right', without taking anything for granted as I was very conscious about the possibility of collusion, consequently I was nervous and some of my initial prompt questions were clumsy, which I tried to alter subsequently. However, my participants' ability to understand my questions and provide answers was amazing to me and they sought clarification where they did not understand. From analysing the data I am aware that this has not had a negative impact upon the interview process, however it is something I will try to be aware of in future research interviews.

The notion of the double Hermeneutic in terms of working with participants' sense making process was also very complex. I felt I was trying to make sense of my participants' experiences while they were trying to make sense of their clients' experiences of Muslim interventions. So findings are a complex synthesis of the researcher making sense of participants making sense of their Muslim clients making sense of Muslim interventions in therapy. Therefore, the perception and experience of Muslim interventions for Muslim clients in therapy is coloured by all three: researcher, participants and their Muslim clients. Researcher, participants and their clients, were all Muslims, this may have run the risk of unintentional collusion, response bias, and taking commonly held beliefs at face value. The researcher however managed this by taking a phenomenological, critical and reflexive stance. I was aware throughout that I was very passionate about the research; therefore the interview schedule, methodological choices, analysis and interpretations were all double checked by the supervisor who was non-Muslim.

Furthermore, verbal feedback gained from research conferences (within the University and outside University) significantly enhanced my ability to be reflexive about what I was doing when I was in the thick of my research. At the same time, I recognised that no matter how aware and reflexive we try to be, as Grosz (1995) points out, "the author's intentions, emotions, psyche, and interiority are not only inaccessible to readers, they are likely to be inaccessible to the author herself" (p 13). There may be limits to reflexivity, and to the extent to which I can be aware of the influences on my research.

Nevertheless, it was exciting to hear some of the statements participants made during the interviews, as it echoed what other Muslim psychologists had already mentioned before. Thus, there was a link between the findings and the literature review. I made mental notes of the themes that were emerging across the interviews. At this stage it was difficult to separate themes from the interview sub-categories/sub-sections, i.e. it seemed that some of the themes were based on questions groupings from the interview schedule. However, after re-reading more structures began to appear. Also, instead of right hand and left hand notes, I have used Track Changes command and colour coded notes for the two-order analysis suggested by Smith et al. (2009). Analysis was verified with the supervisors.

Unfortunately, not all is straightforward and apparent with Muslim therapeutic interventions and models. The meaning of Muslim therapeutic interventions can be confusing as many different models are emerging and developing. Participants also had difficulty defining Muslim interventions. This might have impacted the results, however, it can be argued that Muslim therapeutic interventions are still in its nascent stages and it relies heavily on ancient work which is not available in English language therefore more research is needed which would be more relevant to the context of Muslim clients living in the West.

Some of these interventions were learnt through additional training undertaken by participants. These courses in most cases were not specifically counselling training, but were either Islamic teaching courses which covered an in depth understanding of Qur'anic verses, or a personal mentoring with an Islamic scholar which can raise ethical issues if clients' issues get discussed. Each therapist drew differently from the training

and used it in practice variably. There were only a few courses that specifically taught how to use Muslim interventions in therapy, and it was up to the participants to decipher what, how, and with whom they could use such interventions. With no clear instructions given, it is understandable that the participants themselves would have to put some of these abstract views together so they could be put into practice. This was likely to be a complex procedure. It is not surprising that participants found it hard to explain Muslim interventions during the interview. Whilst there was some clarity about uses or benefits, defining it was a difficult task. In this research, the participants have been able to give an essence or flavour of some Muslim interventions currently being used by them, and their usefulness.

I appreciate that some participants had more experience in applying Muslim interventions than others, but all were still in the process of developing them. Also, I understood there were no prescribed procedures to practice. I believe that there was no particular way of using these interventions and they could be adapted to suit a client's needs. Whilst this made it more complex, it could be made more personal and effective.

I suppose one of my main concerns for this research was to ensure that the findings were new to research and would contribute to the field of counselling psychology. It dawned on me over the course of conducting the research that I too had learnt an enormous amount from it. It has helped me become aware of how passionately I feel about this. I now know that my research has contributed to my knowledge and development as a counselling psychologist. By taking a scientist practitioner stance, I have also learned to contain my urge to collude with the existing literature that draws a clear line between mainstream approaches and Muslim healing tradition. The critical

stance taken for this research right from the beginning has also taught me that the assertions made about Muslim interventions were not always backed up by empirical evidence. It is also important to understand that most participants are researchers and have special interest in the literature concerning Muslim mental health; therefore their responses and experience of Muslim interventions could also be influenced by the existing knowledge. Nevertheless they had learnt through their practice that the incorporation of both Muslim interventions and mainstream approaches was more useful for Muslim clients living in the UK.

The participants and I have learnt that Muslim interventions and models are still in the process of being developed and are not theorized in a coherent way. Furthermore, these models need to be tested within the scientific paradigm of counselling psychology, examined empirically and developed according to scientific principles so that further strategies about their application can be adapted.

This research has inspired me to realise what I might want to do after completing the course, directing me to areas that I would like to study and explore further. I am contemplating researching some of the concepts behind Sufi philosophy and model of self. The research might also raise awareness in the Muslim community about the importance of therapy for mental health difficulties and may address some of their concerns.

As a practitioner, I will continue developing my knowledge about Muslim interventions and use them with my future clients when required. I also understand the importance of enhancing my knowledge of Muslim therapeutic interventions through supervision,

CPD and personal therapy with a therapist who can incorporate Muslim interventions into therapy. The research has also helped me to adopt an open attitude towards other cultures, religions and diversities for all clients regardless of who they might be.

6.1 CONCLUSION

Conducting any research requires determination and motivation, and this is even more relevant to a doctoral thesis. This research is nowhere near perfect but has been a learning process and passionate journey, which hopefully will make a significant contribution to the literature area for therapeutic practice with Muslim clients.

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8 APPENDICES

APPENDIX 1

Ethical Approval Confirmation

From: Chadwick, Darren (Dr)
<D.Chadwick@wlv.ac.uk<mailto:D.Chadwick@wlv.ac.uk>>
Sent: 02 July 2015 11:11
To: Galbraith, Victoria; Banks, Nicolas; Choudhry, Abida
Cc: Clewer, Louise
Subject: Ethics feedback and decision

The Faculty Ethics Panel (Health Professions, Psychology, Social Work & Social Care) has considered and reviewed your submission.

On review your Research Proposal was passed and given approval Code 2 – Approved Subject to Conditions. The conditions for Approval are below.

A. Researcher/Supervisor to Monitor. Please address the minor amendments detailed below. If this is student research, supervisors must ensure the minor amendments have been completed prior to commencement of data collection. A condition of this approval is that Supervisors must read through and check the revised applications and email a confirmation to fehwethics@wlv.ac.uk<mailto:fehwethics@wlv.ac.uk> to confirm they have occurred.

1.2 Title: Exploring therapists' experience of using therapeutic interventions from Muslim perspectives for Muslim clients: Its usefulness, contribution and challenges in the UK.

Researcher: Abida Choudhry

Supervisor: Dr. Victoria Galbraith & Dr. Nick Banks

Decision: Code 2A – Supervisor to monitor

Required Changes

· The University's logo needs to be included into all forms used to communicate with the participants.

· Regarding appendix 1, participants should not be required to request an information sheet, they should be provided with one in order to fully satisfy the requirement for informed / valid consent.

· The recruitment process is not clear; the researcher refers to a variety of potential participants but does not allude to the actual process of first contact, recruitment, permission letters. This needs to be clarified and any ethical issues inherent in recruitment e.g. coercion considered and managed.

Best wishes for the progress of your study.
Yours sincerely

H Paniagua, Dr. H. Paniagua PhD, MSc, BSc (Hons) Cert. Ed. RN RM, Chair – Ethics Panel

D Chadwick

Dr. D. Chadwick PhD, MSc, BA (Hons). PGCE., CPSYCHOL, Chair – Ethics Panel

Reader in Applied Psychology
Faculty of Education, Health & Wellbeing,
University of Wolverhampton, Mary Seacole Building,
City Campus - North, Wolverhampton, UK. WV1 1AD
Tel: +44-(0)1902-323534 Email:
d.chadwick@wlv.ac.uk<mailto:d.chadwick@wlv.ac.uk>

Galbraith, Victoria <V.Galbraith@wlv.ac.uk>

Thu 06/08/2015, 19:02
Choudhry, Abida;
Banks, Nicolas
Inbox
Hi Abida,

I have seen the changes to section 16 and am happy for you to go ahead.

Best wishes,

Vicky

APPENDIX 2

Interview Schedule

Area 1: Professional Counselling/Psychological Training

Q1: What was your training in?

Q2: How long was your training?

Q3: What is the main model that you have been trained in?

Q4: What is your theoretical model of preference?

Area 2: Exploration of Muslim Psychological interventions and their suitability to Muslim clients

Q1: What is your understanding of Muslim Psychological Interventions?

Q2: What is your experience of using these interventions and in what way do you introduce them into your practice?

Q4: Do you use them regularly in your practice with Muslim clients or do you use them in certain situations?

Q3: How do you perceive the need for using these interventions for your clients?

Q3: What was your client's initial response when you used Muslim interventions?

Area 3: Usefulness of Muslim interventions

Q1: Which Muslim Psychological Intervention you found most beneficial for your Muslim clients? (Probe: practical exercise such as recitation of Qur'an or Muslim philosophical concepts).

Q2: How do you assess their usefulness for your clients?

Q3: In your opinion how do Muslim Interventions help to understand Muslim clients' mental health problems?

Q4: Can you describe or give an example of using the above interventions with a Muslim client?

Area 4: Experience of integrating Muslim interventions with western approaches.

Q1: How was your experience of integrating Muslim interventions with western approaches?

Q2: Did you experience any challenges?

Area 5: Contribution to Counselling Psychology

Q1: In your opinion how can these interventions contribute to the counselling psychology field?

Q2: Is there anything you would like to add about your practice that I haven't asked you?

APPENDIX 3

Contact Sheet

Are you a Muslim Counselling Psychologist, Counsellor or Psychotherapist ?

Do you use interventions form Muslim perspectives in therapy with your Muslim clients ?

If so you are prefect to take part in my study.

I am a Third year trainee at the University of Wolverhampton undergoing a professional Doctorate in Counselling Psychology. I am currently recruiting Muslim Counselling Psychologists/Counsellors/Psychotherapists who have been trained in the
UK but have knowledge of Muslim interventions and have been utilising them with their Muslim clients in therapy.

The title of the research project is: Exploring therapists' experiences of using therapeutic interventions from Muslim perspectives for Muslim clients: usefulness, contribution and challenges in the UK.

The aim of the study is to find out more about the therapists' in depth experience of using interventions from Muslim perspectives and about their usefulness and contribution.

Participation will involve taking part in a semi-structured audio-recorded interview, which will be either face-to-face or over the telephone, or Skype depending on your location. Interviews will be carried out at time convenient to you and will last approximately an hour and a half. This research study has been approved by the Psychology Ethics Committee at the University of Wolverhampton.

I am looking to recruit Muslim therapists form any ethnic background.

This research is being supervised by Dr. Victoria Galbraith (Email: V.galbraith@wlv.ac.uk) and Dr. Nicolas Banks (Email: Nick.banks@wlv.ac.uk) at University of Wolverhampton.

I would sincerely appreciate your participation in this research project. If you would like to take part in this research, please contact me using the details below and I will send you an information sheet.

Email: A.choudhry2@wlv.ac.uk or

anchoudhry@hotmail.com

Thanks in anticipation

Abida Choudhry

APPENDIX 4

Participant Information Sheet

Research study- Professional Doctorate in Counselling Psychology at University of Wolverhampton

Title: Exploring therapists' experiences of using therapeutic interventions from Muslim perspectives for Muslim clients: usefulness, contribution and challenges in the UK.

I am a third year trainee Counselling Psychologist at the University of Wolverhampton on Professional Doctorate in Counselling Psychology course. As a part of the course requirements, I am conducting a research study, which is intended to explore how Muslim therapists experience using Muslim interventions in their practice with Muslim clients. The interview questions used for the study are designed to explore your experience of utilizing psychological interventions form Muslim perspectives, deciding its suitability and usefulness, your perception of its contribution to the counselling psychology field and the challenges that you might experience in its application in the UK. These are the areas perceived to be at the centre of the study's aim.

It is hoped that the current study will contribute to fill the gap in the knowledge about the experience and perception of practical implications of these interventions and it may offer a more holistic understanding of Muslims' mental health problems and healing and may strengthen Muslim client's presence in therapy.

What will I have to do if I take part?

If you take part, you will be asked to participate in an individual semi-structured interview, which will be audio-recorded and should take approximately an hour and a half. An appointment will be arranged for conducting the interview either face-to-face, over the telephone or Skype, at time convenient for you. A consent form and a demographics form needs to be signed prior to the interview.

Can I stop taking part?

Yes. Your participation is voluntary and you can stop taking part in the study up until the analysis of data begins (01-10-15), without giving a reason.

What are the possible disadvantage or advantages of taking part?

There are no particular disadvantages or risks. You are not required to share any information that you are not comfortable about. And your participation will be helpful for Muslim community and counselling psychology field.

What if there is a problem?

If you are concerned about your participation in the study and would like to speak to someone in the research team, please contact Dr. Victoria Galbraith at V.Galbraith@wlv.ac.uk.

What will happen to the information?

The audio-recorded material will be stored in secure locations and destroyed following completion of the research project. The transcribed data will be kept for up to five years, however, will not be identifiable. You can have access to the research summary

by requesting it from me at the email address given below. Any information that might identify you will be anonymised. No identifiable details will appear in any documents or in the final report. Complete confidentiality cannot be promised, as information gathered in the interview is the actual data of the project. However, your anonymity is ensured, and all data obtained will be treated with respect and dignity.

What will happen to the results of the research study?

The data will be available to a rang of people, including students, mental health professionals and researchers. However, the anonymity will be ensured.

What happens next?

If you decide to be part of the study after reading the information, please contact me via email or phone me to arrange an appointment. If you would like to have more information about the research please contact me.

Thank you

Abida Choudhry, Counselling Psychologist in Training

a.choudhry2@wlv.ac.uk

anchoudhry@hotmail.com

APPENDIX 5

Consent Form

Please sign each statement

- I the Undersigned voluntarily agree to take part in the study on how Muslim therapists use interventions from Muslim perspectives in their practice with Muslim clients. _____
- I have read and understood the Information Sheet provided. _____
- I have been given a full explanation by the investigator of the nature and purpose of the study and have been given the opportunity to ask questions on all aspects of the research. _____
- I also understand that all personal data relating to volunteers is held and processed in the strictest confidence and in accordance with the Data protection Act (1998). _____
- I am aware that I can withdraw my participation in the study up until analysis of data (01-10-15). _____
- I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved. _____
- I therefore confirm that I have read and understood the above and freely consent to participate in this study. _____

Name of Volunteer …….

(Block Capital)

Signed ……...

Date ……

On behalf of those involved with this research project, I understand that, in respect of the questionnaires, professional confidentiality will be ensured and that the use of the data will be for the purpose of research only. The anonymity of the above participant will be protected.

Name of the Investigator: Abida Choudhry

Signed …….

Date …….

APPENDIX 6

Demographic Information

Your answers to the following questions are strictly confidential and are only for research purposes. Nevertheless, if you would prefer not to answer any questions, please feel free not to.

1. Male -------- Female---------
2. How old are you? [ ] years
3. Your Race/ethnicity?

   ----

4. Qualifications?

   ----

5. Professional designation/ title (s)

   ----

6. For how many years have you been practicing as a psychological therapist?

   ----

7. For how long you have been working with Muslim clients?

   ----

8. Please list the techniques/interventions from Muslim perspectives that you have been using in you practice?

---

9. Were you trained in these techniques or are they knowledge based?

_____

APPENDIX 7

Debrief Sheet

Title: Exploring therapists' experiences of using therapeutic interventions from Muslim perspectives for Muslim clients: usefulness, contribution and challenges in the UK.

Thank you for taking part in this interview. This study will hopefully make a significant contribution to the Muslim community, British society and counselling psychology profession. This research was designed to gain insight into Muslim therapists experience of using Muslim interventions. It was particularly aimed at obtaining greater understanding into how Muslim interventions are used in therapeutic setting by Muslim therapists with their Muslim clients, how the effectiveness is assessed and what challenges a therapist might face.

Despite several recommendations for utilizing the therapeutic techniques from Muslim perspectives for Muslim clients in therapy (Dharamsi & Maynard, 2012; Hussian, 2009; Inayat, 2001; Utz, 2012), research on this area has lagged behind. This study therefore addresses the gap in the literature about the lack of qualitative research on Psychological Interventions from Muslim perspectives. Muslim psychologists, have argued that because of it's grounding in the secular worldview, Western psychology may not capture the holistic understanding of Muslim clients thus unable to address their mental health problems adequately and effectively (Badri, 1979; Keshavarzi & Haque, 2013; Walpole et al., 2012). Therefore, further knowledge could provide new

information on how these interventions can be utilize to help Muslim clients in therapy.

The audio file of this interview will be kept in a locked and secure place and transcribed into a text document (anonymously) and will later be deleted.

The data will be analysed and will be available to a range of people, including students, health professionals and researchers. However, you will not be identified.

If you have any questions about this research please contact

Abida Choudhry, Counselling Psychologist in Training

A.choudhry2@wlv.ac.uk 0r 07867410786

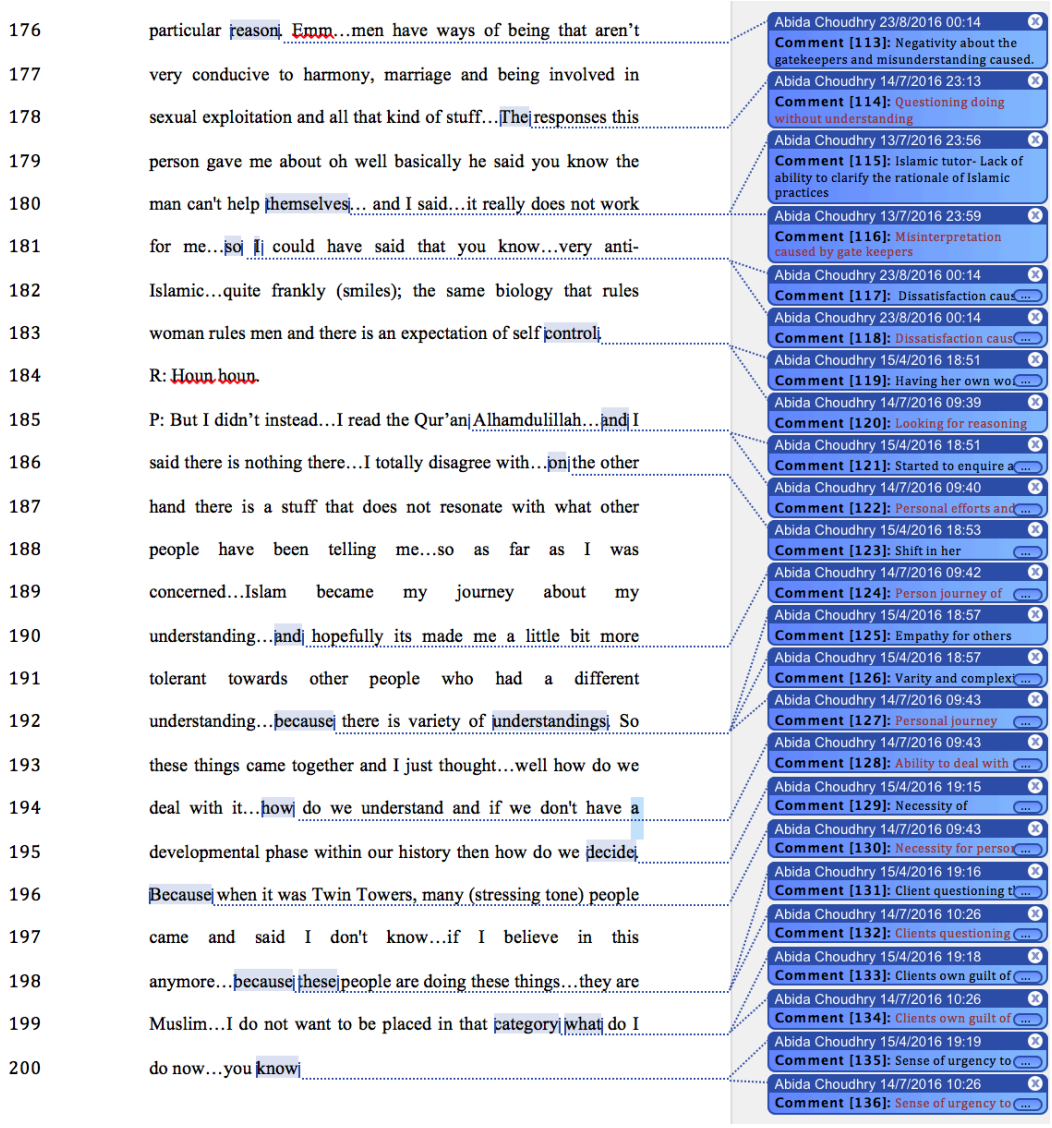
If you have any concerns about your participation please contact

Dr. Victoria Galbraith (Email: V.galbraith@wlv.ac.uk) and Dr. Nicolas Banks (Email:

(Email: Nick.banks@wlv.ac.uk) at University of Wolverhampton

APPENDIX 8

Extract of Annotated Transcript of Participant 1



176 particular reason. Emm…men have ways of being that aren't
177 very conducive to harmony, marriage and being involved in
178 sexual exploitation and all that kind of stuff…The responses this
179 person gave me about oh well basically he said you know the
180 man can't help themselves… and I said…it really does not work
181 for me…so I could have said that you know…very anti-
182 Islamic…quite frankly (smiles); the same biology that rules
183 woman rules men and there is an expectation of self control
184 R: Houn houn.
185 P: But I didn't instead…I read the Qur'an Alhamdulillah…and I
186 said there is nothing there…I totally disagree with…on the other
187 hand there is a stuff that does not resonate with what other
188 people have been telling me…so as far as I was
189 concerned…Islam became my journey about my
190 understanding…and hopefully its made me a little bit more
191 tolerant towards other people who had a different
192 understanding…because there is variety of understandings. So
193 these things came together and I just thought…well how do we
194 deal with it…how do we understand and if we don't have a
195 developmental phase within our history then how do we decide.
196 Because when it was Twin Towers, many (stressing tone) people
197 came and said I don't know…if I believe in this
198 anymore…because these people are doing these things…they are
199 Muslim…I do not want to be placed in that category what do I
200 do now…you know

Abida Choudhry 23/8/2016 00:14
Comment [113]: Negativity about the gatekeepers and misunderstanding caused.

Abida Choudhry 14/7/2016 23:13
Comment [114]: Questioning doing without understanding

Abida Choudhry 13/7/2016 23:56
Comment [115]: Islamic tutor- Lack of ability to clarify the rationale of Islamic practices

Abida Choudhry 13/7/2016 23:59
Comment [116]: Misinterpretation caused by gate keepers

Abida Choudhry 23/8/2016 00:14
Comment [117]: Dissatisfaction caus…

Abida Choudhry 23/8/2016 00:14
Comment [118]: Dissatisfaction caus…

Abida Choudhry 15/4/2016 18:51
Comment [119]: Having her own wo…

Abida Choudhry 14/7/2016 09:39
Comment [120]: Looking for reasoning

Abida Choudhry 15/4/2016 18:51
Comment [121]: Started to enquire a…

Abida Choudhry 14/7/2016 09:40
Comment [122]: Personal efforts and…

Abida Choudhry 15/4/2016 18:53
Comment [123]: Shift in her …

Abida Choudhry 14/7/2016 09:42
Comment [124]: Person journey of …

Abida Choudhry 15/4/2016 18:57
Comment [125]: Empathy for others

Abida Choudhry 15/4/2016 18:57
Comment [126]: Varity and complexi…

Abida Choudhry 14/7/2016 09:43
Comment [127]: Personal journey …

Abida Choudhry 14/7/2016 09:43
Comment [128]: Ability to deal with …

Abida Choudhry 15/4/2016 19:15
Comment [129]: Necessity of …

Abida Choudhry 14/7/2016 09:43
Comment [130]: Necessity for perso…

Abida Choudhry 15/4/2016 19:16
Comment [131]: Client questioning t…

Abida Choudhry 14/7/2016 10:26
Comment [132]: Clients questioning …

Abida Choudhry 15/4/2016 19:18
Comment [133]: Clients own guilt of …

Abida Choudhry 14/7/2016 10:26
Comment [134]: Clients own guilt of …

Abida Choudhry 15/4/2016 19:19
Comment [135]: Sense of urgency to …

Abida Choudhry 14/7/2016 10:26
Comment [136]: Sense of urgency to …

APPENDIX 9

List of Chronological Themes for Participant 1

1. Holistic approach
2. Training: PhD
3. Training in both: traditional psychology and Islamic
4. Very qualified
5. Many years of Training
6. Integrative training
7. Model of Preference person entered
8. Perceived Shift in more rigid paradigms like CBT
9. Integrative therapist
10. Shift in CBT
11. Way of working: Person Centred
12. Not one size fits for all
13. Western model limited understanding of self
14. CBT is Partial
15. In Existential model of self is vague
16. Psychodynamic anti-Islamic?
17. PD robust model of self but still limited
18. Childhood has prime importance
19. Models shifting and expanding
20. Being in time: Existential
21. Knowledge is socially constructed
22. Being in time. Social construction of knowledge
23. Parallels between humanistic and Islamic

24. Active construction of knowledge
25. evidence- based embedded in a socio economic context
26. Evidence-based is biased.
27. Power dynamics
28. Private practice co-creation
29. Client centered
30. Evidence based whose agenda it is.
31. Conflict of interest
32. Metaphor to express complexity about evidence-based
33. Proof
34. Validity of the tools is questionable
35. Limited validity
36. Misdiagnosis
37. Tools with certain agenda
38. Counselling psychology first then Islamic counselling
39. Personal journey
40. Clients decision
41. Openness to explore any religion
42. Working with other religion
43. Religion not being important to client (Christian)
44. Religious beliefs part of grief process
45. Shared understanding
46. Therapist's understanding of clients' understanding
47. Being in time
48. 9/11 identity crisis for Muslims

49. Urge to review long held beliefs
50. Complexity about diversity of understanding
51. Challenging Islamic interpretations
52. Questioning doing without understanding
53. Misinterpretation caused by gate keepers
54. Dissatisfaction caused despair. Existential
55. Looking for reasoning
56. Personal efforts and journey
57. Personal journey facilitated empathy
58. Ability to deal with the Complexity
59. Necessity for personal development
60. Clients questioning their religion after 9/11
61. Sense of urgency to redefine their values
62. Journey with religion
63. Choice and agency in religion: parallels with existential
64. Sartre's idea of we choose therefore we live. Existential Knowledge
65. Parallels: choice
66. Same human conditions
67. The way Islam is portrayed by the gatekeeper its Restrictive and counter productive.
68. Religious misinterpretations of mental health problems
69. Empathy due to personal experience
70. Matching participants subjectivity through shared experiences
71. Rigid thinking about Islam
72. Critic about conflicting interpretations

73. Sects intolerant of each others

74. Frustration about finding a common ground

75. Mutual conflict challenge for Islamic counselling

76. Working with diversity within diversity.

77. Difficulty in changing perceptions against commonly held beliefs

78. Understanding about clients' frustration

79. Gatekeeper can be antagonistic

80. Frustration about the religious authority: similar to church dogma

81. Younger Muslim women have very strong ideas about religion

82. Generational comparison

83. Generational shift

84. Shift in younger generation

85. Perceived sense of isolation

86. More Muslim voices in the field

87. They don't feel alone

88. Sense of connection of sharing the same ideas and passion

89. More shared understanding is developing

90. Younger generation trying to find a common ground

91. Even small collective understanding

92. Less islamophobia now

93. Should come form client otherwise risk of imposing your agenda

94. Unethical if imposing

95. Clients expectations about Islamic therapy: magic cure

96. Disappointment

97. Islamic therapy is still a therapy

98. Explaining the process of therapy, view about human being, strategies and therapist role explaining
99. They don't like it calling it Islamic counselling: restriction.
100. Not Muslim enough
101. Restriction about credibility of doing Islamic work
102. Complexity of sharing common ground with client
103. What clients' expectations are
104. Expectations about Islamic approach: quick fix and magic cure
105. Demands hard work and taking responsibility: parallels
106. Islamic interventions at assessment stage
107. Assessment: understanding clients worldview
108. Worldview not just religion: holistic
109. Including culture
110. Informed choices
111. Entirely client's choice
112. For all the clients
113. Complexity of defining Muslim interventions
114. Islamic understanding of their issues
115. Finding meanings in suffering form Islamic perspectives
116. Alternative perceptions
117. Punishment vs reward
118. Challenging the negative thinking: parallels
119. Finding meanings through alternative thinking
120. Facilitate more open mindedness
121. Healthy vs counter productive explanation

122. Islamic concept of trails
123. Testing explanation to see which fits.
124. Which hypothesis resonates.
125. Comparison with Imam's focus on doing rather exploring
126. Intentions are important
127. Complexity of the dynamics
128. In depth exploration of rationality of actions
129. Exploration of complex motives
130. Understanding intention and motives rather focusing the 'doings'
131. Intentions are more important than actions: Islamic belief
132. It's a process
133. Therapist being non-judgmental
134. Enforcing hope and reliance on Allah
135. Therapist more empathetic of clients struggle than imams
136. Less of a rigid focus
137. Understanding the doing, idea of being
138. Your positioning is important
139. Understanding limitations and keeping hope
140. Looking at the possibilities, one step at a time: CBT
141. Working with client's limitations: being realistic
142. Touches heart: Islamic concept: meaningful
143. Long ball of wool: Metaphor of long journey
144. The complexity of looking at spirituality
145. Sense of connection after exploration
146. Religious practices without exploration does

147. Presence of heart is important: parallel with mindfulness
148. Understanding and practice with experiential quality is important
149. Long developmental journey not immediate cure
150. Importance of therapist's own journey in the therapeutic process: positive or negative
151. A primary human connection is essential
152. Not Muslim enough, barrier of working with Muslim therapist, credibility
153. Muslim clients feel more open with Non- Muslim therapist
154. Fear of stigma with MT
155. A primary connection is more important that being Muslim
156. Varied experience of using Muslim interventions
157. Validating their struggles
158. No quick fix
159. Forgiveness Islamic element
160. Paying attention to psychological process of forgiveness
161. Empathy and compassion
162. More contented with the outcomes of therapy
163. Reliance on Allah about outcomes
164. Embracing her limitations: being good enough
165. We plant the seed, they germinate: metaphor of starting a process
166. Human limitations and reliance on Allah for success
167. Reliance of Allah is a relief
168. Your best is required
169. Reliance on God help Accepting her limitation
170. Everything is planed by Allah

171. Working with clients' strengthen and understanding: assessment
172. Dialectic relationship
173. Willing and excited to try
174. Disappointment about not having magic cure
175. Higher expectations from Islamic way of working
176. Review your work
177. Recitation of little surah during the session
178. Avoidance about process
179. Its an inner process
180. As home work. CBT parallel
181. Prayers in therapy but with good rationale
182. Prayer as home work
183. Prayer to use in group therapy
184. Prayer in sessions may feel like being imposed
185. Prayers in the group get enhanced
186. Short prayer may be suitable in the session
187. Long verses are time consuming if done in the session
188. Therapeutic process continues outside therapy room
189. Process needs to happen
190. Is it avoidance
191. Readiness before strategies
192. Rationale and meanings behind
193. Doing with understanding: interpretation of the verse
194. Islamic concept of heart being opened, healthy or diseased.
195. If heart is closed less impact: Metaphor of dried plant.

196. Slow recovery if heart is closed
197. Understanding and openness of heart
198. Openness of heart
199. Islamic concept of gratitude
200. Less effective if heart is not open
201. Understanding and processing vs practices
202. Search for meaning
203. One step at a time: CBT
204. Limitation: Muslim theory of mental health being weak
205. More work needed
206. Islamic concepts of life after death helpful in grief process
207. Therapy makes you feel worst before you get better
208. In Psychosis disengagement with reality can be counter productive
209. Intense meditation or inward searching not for psychosis
210. Can leave them disengaged from reality
211. No clash between main stream and Islamic
212. Good rationale for any intervention
213. If it fits with clients' needs
214. Not prescriptive
215. Good rationale and fit for clients' needs
216. Does not clash
217. Fear of death: existential: in line with Islamic
218. Limitation of western model: existential no meanings.
219. Strength: Islam gives meanings
220. Strength: Model of human being.

221. Understanding of human being good starting point.
222. Counselling psychology: open minded.
223. Islamic Strength: meanings
224. Diversity within Muslims
225. Consider their understanding of Islam
226. Don't make assumptions about their understanding of the basics
227. Imams lack education
228. Holy Prophet was the best counsellor
229. Imam only oral tradition no meanings, less compassion
230. Focus on doing
231. Collaborating with imams
232. Consideration: Explicit about using Muslim interventions.
233. Being congruent, therapy is co-creation and the context of the therapist is there.
234. Diversity in Islamic models
235. No model will be perfect
236. Strength: Diversity of Islamic models

APPENDIX 10

Extract from Colour Coding for Clustering on Chronological Themes for Participant 1

50. Complexity about diversity of understanding
51. Challenging Islamic interpretations
52. Questioning doing without understanding
53. Misinterpretation caused by gate keepers
54. Dissatisfaction caused despair. Existential
55. Looking for reasoning
56. Personal efforts and journey
57. Personal journey facilitated empathy
58. Ability to deal with the Complexity
59. Necessity for personal development
60. Clients questioning their religion after 9/11
61. Sense of urgency to redefine their values
62. Journey with religion
63. Choice and agency in religion: parallels with existential
64. Sartre's idea of we choose therefore we live. Existential
65. Parallels: choice
66. Same human conditions
67. The way Islam is portrayed by the gatekeeper: restrictive and counter productive.
68. Religious misinterpretations of mental health problems
69. Empathy due to personal experience
70. Matching participants subjectivity through shared experiences
71. Rigid thinking about Islam
72. Critic about conflicting interpretations
73. Sects intolerant of each others

APPENDIX 11

Final Themes for Participant 1

Muslim Therapeutic Interventions

Assessment and formulation

Prayers in group therapy

Reading to Qur'an

Challenging clients preconceptions by alternative hypothesis

Religious, cultural and individual worldview

Use of Islamic beliefs and practices in therapy

Psychological and spiritual aspects of Forgiveness

Religious beliefs for grief

Belief about punishment verses trials

Strengthens of Muslim Interventions

Muslim clients' need

Holistic

Client's choice

Search for meanings in suffering

Working with Spirituality

Distinctive features

Reliance on Allah

Islamic notion of self

Shared language

Shared understanding

Enhanced empathy

Hope

Therapist's contentment through reliance on Allah

Limitations of Muslim interventions

Complexity around definition

Long prayer cannot be used in therapy

Mainstream approaches

Not universal

Limited understating of self

CBT/psychodynamic being partial

Limited in their focus: PD on childhood

Psychodynamic anti Islamic

In conflict with clients' religious worldview

Lack of understanding of clients' beliefs and therapeutic rupture

Not one size fits for all

Models are shifting and expanding: CBT is less rigid now

Parallels

Parallels between humanistic: client centered, potential for growth

Similarity with existential: choice and agency

CBT: mindfulness and heart being present

Journey of becoming Muslim therapist

Struggle with doing: religious practices

Empathy for clients' struggles

Intentions more important than actions

Role of Muslim therapist/ therapeutic relationship

Respecting clients choices

Exploration rather imposing

Use of shared language

Recommendations for therapy

Client's choice and autonomy

Openness to explore religion

Respecting clients' worldview

Challenges of using Muslim interventions

Perceived sense of isolation

No common ground

Difficulty in challenging commonly held beliefs

High expectations

Credibility issues

Relevance to therapy

More meaningful for Muslim clients

Offering therapy that is more relevant

APPENDIX 12

Grouping forming Superordinate Theme 1: Therapeutic Interventions for all participants

Participant 1

Muslim Therapeutic Interventions

Assessment and formulation

Prayers in group therapy

Reading to Qur'an

Challenging clients preconceptions by alternative hypothesis

Religious, cultural and individual worldview

Use of Islamic beliefs and practices in therapy

Psychological and spiritual aspects of Forgiveness

Religious beliefs for grief

Belief about punishment verses trials

Strengthens of Muslim Interventions

Muslim clients' need

Holistic

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CBT/psychodynamic being partial

Limited in their focus: PD on childhood

Psychodynamic anti Islamic

In conflict with clients' religious worldview

Lack of understanding of clients' beliefs and therapeutic rupture

Not one size fits for all

Models are shifting and expanding: CBT is less rigid now

Parallels

Parallels between humanistic: client centered, potential for growth

Similarity with existential: choice and agency

CBT: mindfulness and heart being present

Participant 2

Muslim interventions

Less formal assessment

Beliefs about supernatural

Qur'anic notion of self

Spiritual explanation of healing

Seeking protection from Allah

Disease of heart-purification of soul

Prayers

Ziker

Working with counter productive cognitions

Strengthens of Muslim Interventions

Search for meaning

Clients feel heard

Working with difficult clients

Beliefs validation

Life changing

Effective

Non pathological

Allow more in-depth work with Muslim clients

Impact on heart and soul

Client stayed in therapy

More meaningful

Allow Systemic work, more collectivist

Limitations of Muslim interventions

English literature is limited

Not being translated

Distinctive

Use of shared language

Work satisfaction doing; it for Allah

Reliance on Allah

Enhancing their connection with Allah

Sake of Allah

Understanding of self

Gives hope

Mainstream approaches

Integration of both is more effective

One without other-no use

Very valuable

Founders-anti-religious

Questioning whether conflicting with Islam

Individualistic

Parallels

Parallels with Christianity & Pastoral counselling

Similarity in aspects of theory of self

Parallels between DBT and Islam: gratitude

CBT and working with cognitions

Participant 3

Muslim Therapeutic Interventions

Islamic teachings of healing

Challenging unhealthy and commonly held beliefs

Forgiveness

Qur'anic metaphors and stories

Names of Allah: understating the meanings

Eastern-Socio centric concept of self and higher self

Strengthens of Muslim interventions

Helps working with context: religious and cultural

Current need

Address social, family, religious, psychological issues

Meaningful

Holistic: No mind body split

Religion a source of resilience but unhealthy when distorted

Effective

Suitable for Muslim clients religious and cultural needs

Limitations of Muslim interventions

Several models but need to be developed more

Lack of rigorous theoretical knowledge

Distinctive Features

Shared language

Collective power of healing

Using familiar narratives

Connection with community and Identity

Therapeutic alliance

Concept of self and spiritual growth

Enhance connection with God

Empathy through shared journey

Touching and moving for clients

Speak to their heart

Different philosophical grounds

Mainstream Therapeutic approaches

Incredibly useful

Limitations of Mainstream approaches

Muslim clients' fear about Western therapist individualistic thinking

Perceived cultural gap

Measures being Western

Partial understanding of self

Individualist verses collectivist

Decontextualizing

Does not address religion

Validity/ norms for Muslim clients

Different goals for therapy

Conflict of interest

Premature dropouts

Therapist unable to capture the uniqueness

Not universal

Parallels

Systemic therapy: Family and network

<u>Participant 4</u>

Muslim Therapeutic Interventions

Allah's names

Islamic beliefs

Purification of Intentions

Sufi concept of love in therapeutic alliance

Prayer

Qur'anic concepts

Notion of self

Strengthens of Muslim interventions

Community need

More effective

Stronger impact

Feel safe to be open

Beliefs accepted

Need for spiritual healing for mental health issues

More committed

Transcendence

Higher potential spiritually grounded

Problem verses growth

Spiritual

Holistic

Client's preference about spirituality

Client felt understood

Cost effective

Improved outcomes on Anxiety and depression

Can be used for non-Muslim

Meaningful

Distinctive features

For sake of Allah

Trust in Allah

Work satisfaction

Shared understanding

Empathy

Enhanced Therapeutic alliance

Notion of self

Mainstream Therapeutic approaches

Useful

Western Scholarship is advanced

Psychology is global not Western

Integration is more helpful

Utilisation of all the models is good

All the models has value and something to offer

Limitations of Mainstream approaches

Not deep enough

Not deeply spiritual

Lack of understanding of Muslim beliefs

Psychologists biased about religion

Client's fear of being misunderstood

Limited for religious issues

Parallels

Non pathologising: ethos of counselling psychology, existential therapy

Humanistic unconditional positive regard verses Sufi concept of love

Participant 5

Muslim Therapeutic Interventions

Assessment of clients needs

Islamic teachings

Religious beliefs: Life after death

Ghazali's Notion of self

Sufism

Qur'an and Sunnah's knowledge

Challenging the preconceived ideas

Working with Supernatural

Strengthens of Muslim interventions

Client satisfaction

Client value

Client's preference

Allows in-depth exploration

Helped client's spiritual demands

Effective for depression

More effective

Spiritual explanation of mental health

Holistic: Psychological and spiritual component

Low drop out

Facilitate spiritual growth

Limitation of Muslim interventions

Not developed enough

Distinctive features

Notion of self

Enhanced working alliance

Spiritual growth

Mainstream Therapeutic approaches

Marrying the two is better

Limitations of Mainstream approaches

Client's fear of being misunderstood

Frustration of explaining beliefs

Less cost and time effective

Parallels

Islamic counselling is similar to other approaches

Person centered- client centered

Participant 6

Muslim Therapeutic Interventions

Assessment and formulation

Theory of self

Work with true Dream

Working with the concept of Fitrah

Concept of disease of heart

Ziker

Strengthens of Muslim interventions

Holistic

Validating client experiences

Clients cultural and religious understating

Comprehensive understanding of self

Comprehensive understanding of human nature self

Limitation of Muslim interventions

Based on Islamic teachings may be less effective for non-religious clients

Distinctive features

Unique concept of self

Spiritual dimension is central

Self realization- journey towards Allah

Reliance on Allah can be empowering

Spiritual growth

Mainstream Therapeutic approaches

Should use all the models

Limitations of Mainstream approaches

Medical model

Different culture

Different philosophies

Partial and surface

Not comprehensive model of self: partial

Limited in dream analysis

Limited spiritual insight

Limited understanding of clients' issues

Denied aspects of Muslim perspectives

Conflict of interests

Beliefs dismissed

Not universally applicable

Limited understating of human nature

Psychodynamic no room for spirituality or true dreams

CBT is not suitable to explore deep beliefs

Outcome measures are biased

Scientific domain in conflict with religion

Psychology with spiritual dimension is damaging

Western models-conflicting with Islamic teachings. e.g. dream analysis

Parallels

Jungian: dream, spirituality,

Marry the two is important

CBT: Cognitions

APPENDIX 13

Final Grouping for Superordinate Theme 1: Therapeutic Interventions and its Subordinate Themes

Mainstream Therapeutic Approaches

Mainstream approaches are useful and beneficial for Muslim clients

Western scholarship being advanced

Psychology is Global rather than Western

All the models have aspects that are valuable

Mainstream approaches are integral and indispensable part of the practice

Limitations

CBT/psychodynamic partial and limited understating of self

Psychodynamic unable to understand Islamic notion of true dream

Lack of understanding of Muslim clients' spiritual or religious beliefs

Secular or limited understating of spirituality

Muslim clients' fear about individualistic worldview

Measures being Western

Partial understanding of self

Individualist verses collectivist

Decontextualizing

Does not address religion

Validity/ norms for Muslim clients

Different goals for therapy

Conflict of interest

Premature dropouts

Therapist unable to capture the uniqueness

Not universal

Not deeply spiritual

Clients fear of being misunderstood

Religiosity

Some psychologists biased about religion

Religion verses science debate

Therapeutic rupture, high drop out

Muslim Therapeutic Interventions

Assessment of client's needs

Religious and spiritual beliefs (e.g. punishment verses test and trials, Destiny, life after death; supernatural cause)

Religious practices (e.g. Prayers, Ziker, Du'a, reading Qur'an)

Stories from Qur'an and Sunnah

Notion of self

Allah's names

Sufism

Why Muslim interventions

Meet Muslim client's cultural and spiritual needs

Muslim clients' preference and meaningful to them

In line with Muslim religious and cultural context

Different philosophical grounds

Comprehensive understanding of self

Holistic: spiritual and psychological healing

Based on Collectivist values

Useful: improved outcomes

Low drop out

Muslim clients felt understood

Acceptance of complex beliefs such as supernatural causes

Muslim clients felt validated

Facilitated spiritual growth as well as psychological

Similar But distinct

Distinctive feature

Unique concept of self

Shared language

Collective power of healing

Using familiar narratives

Connection with community and Identity

Therapeutic alliance

Spiritual growth

Enhance connection with God

Empathy through shared journey

Touching and moving for clients: Speak to their heart

A source of resilience through reliance on God

Similarities

Similarities with CBT: cognitions, mindfulness

Humanistic/Person centered: unconditional positive regard, empathy, congruence

Existential: Choice/ agency, spirituality

Jungian Psychology: True dreams, spirituality

Integration

Integration of both approaches is more useful